

**Exploring foster carers' perceptions of the long-term effectiveness of the
Fostering Changes training programme**

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Abstract

This thesis describes a study that explored how foster carers perceive and experience the effects of participating in the Fostering Changes programme in the 13-15 month period following training. This was achieved using a qualitative approach. Interpretative Phenomenological Analysis (IPA) informed both the data collection and analysis. Interviews were carried out with five carers who were part of a group that had completed the Fostering Changes programme through a community organisation in the Canterbury region. Analysis of the interviews revealed five superordinate themes: Fostering Changes was a beneficial training programme; the need for further professional support post training; the challenges of fostering continue; variability in carers' confidence; training for carers is important. Overall, the findings indicated that Fostering Changes is a well-designed programme that has had an enduring positive impact on these carers' lives. Nevertheless, the results suggest that carers' need for training, support, and clinical services, cannot be solely met through a single, time-limited, group training programme. The five themes are discussed in detail and are compared to the existing literature. Implications and potential future research are also outlined, and recommendations for the Fostering Changes programme are suggested.

Chapter 1: Introduction

This thesis reports on the findings of a qualitative study which was carried out to explore how foster carers perceive and experience the effects of participating in the Fostering Changes programme in the 13-15 month period following training. Chapter one provides an introduction to foster care including its history, the foster care system today, the characteristics of children in care, the challenges of providing foster care, and foster carer support. Chapter two provides a literature review on carer training programmes including Fostering Changes, and ends with a rationale for the current study. Chapter three describes the research methodology and method for the qualitative study. Chapter four summarises the study results, and Chapter five comprises the discussion.

What is foster care?

Foster care is provided for children who are not being adequately cared for by their own biological parents or primary caregivers. Reasons for removing a child from parental care include the child's exposure to significant adversity such as emotional and physical abuse, and neglect. The aim of foster care is to provide these children with a safe and emotionally responsive caregiving environment that can help to promote their developmental recovery (Department of Child Youth and Family, 2015b; Pecora, Whittaker, & Maluccio, 1992; Tarren-Sweeney & Vetere, 2014). Foster carers are volunteers who provide care for these children in their own home, often alongside their own biological children. A friend, family member or non-relative in the community can apply to become a foster carer. The carer must be a trusted adult who is able to make a commitment to the child and provide a safe and stable home environment. Foster carers are typically assessed, may receive a basic level of introductory training, and then become registered with a local government or independent agency (Department of Child Youth and Family, 2015a; Nutt, 2006; Wilson & Sinclair, 2003). Foster carers are not regarded as substitute parents; they instead form part of the foster child's overall family support network and care team. Their services are typically temporary with the goal of returning the child to their birth parents when possible (Nutt, 2006; Pecora et al., 1992).

The fostering task can be very rewarding and bring great satisfaction to the lives of foster carers. There is however also a considerable burden that comes with providing this care (Farmer, Moyers, & Lipscombe, 2004; Nutt, 2006; Sinclair, Gibbs, & Wilson, 2004). The children that enter the care system have complex and severe emotional, behavioural, and

social difficulties which closely resemble clinical populations, and are largely the result of histories of parental maltreatment (Tarren-Sweeney & Hazell, 2006). This can make fostering a very challenging task. Foster carers open up their homes in the hopes of making a difference to the lives of these children but by doing this they are also putting themselves and their own family at risk for stress, conflict, and emotional strain (Sinclair et al., 2004). Placements can breakdown when foster carers are no longer able to cope with the child's difficulties and the negative impacts fostering has on themselves and their family. These placement disruptions can be detrimental to both the foster carer's and foster child's health and wellbeing (Farmer et al., 2004; Sinclair et al., 2004). To maximise the therapeutic potential of foster care and increase the supply of carers, support and effective training programmes are needed.

History of foster care

Early natural forms of foster care date back to biblical times. There is also evidence that during the Viking Age, Viking children were sent to be raised by more noble families (DaSent, trans. 1861). During the sixteenth century English historical records reveal that young orphans were often placed in the care of nurses (Nutt, 2006). In the eighteenth century of Colonial America, many children were indentured to non-relative families by local government officials, where they were provided with their basic needs and taught a trade. Indenture was common for orphans or children who came from poor families (Hacsi, 1995). This use of indenture began to diminish around the middle of the nineteenth century, and between 1830 and 1860 orphan asylums became the predominant care placement for dependent children including those children from impoverished families (Hacsi, 1995; Schene, 1998). These institutions received a great deal of criticism, and it was argued that children would benefit more by being placed within a family. In 1853 Minister Charles Loring Brace founded the New York's Children's Aid Society (CAS) which promoted free foster homes for children instead of institutions (Crosson-Tower, 2007; Hacsi, 1995; Schene, 1998). This began the movement of formal family foster care in the U.S (Pecora et al., 1992). Children from urban slums, who were not having their basic needs meet (e.g. food and shelter), were sent by train to live in rural homes with farming families (Schene, 1998). Indenture contracts were not made but older children were still required to earn their keep through farm labour. This can be seen as the early beginnings of foster care. The system

implemented by CAS was largely designed to protect children from their parents who were regarded as being incapable of providing adequate care (Hacsi, 1995).

An early form of foster care emerged in the 1890s with the introduction of boarding homes. Board payments were made to families in the hopes that these children would not have to earn their keep through labour. By the 1930s institutional care and free placing out were on the decline, with children more likely to be boarded-out (Hacsi, 1995). Given that agencies were paying families for boarding children, there was more emphasis on assessing the quality of the placement home to ascertain whether it was an adequate caring environment for a child (Hacsi, 1995). From this point onwards the number of children in foster care rose dramatically. This was largely attributed to the increase in federal funding used to support foster care (Crosson-Tower, 2007; Hacsi, 1995).

Foster care originally aimed to separate children from their birth parents in an attempt to rescue them from potentially damaging home environments (Schene, 1998). With the permanency planning movement during the 1970's there was a shift away from this rescuing orientation. The aim during this time was to promote stability of care and continuity of child-adult relationships (Pecora et al., 1992). It was established in response to a large number of children in the care system experiencing harmful separations, instability, and indefinite care plans. Permanency planning was legislated in the U.S under the Adoption Assistance and Child Welfare Act 1980 (Barber & Delfabbro, 2004; Pecora et al., 1992). The aim was to provide appropriate services to prevent children from being separated from their birth parents in the first place. If out-of-home placement could not be prevented then the reunification with the birth parents became the priority. Adoption and long-term foster care were alternative options to promote stability where reunification was not possible (Barber & Delfabbro, 2004; Pecora et al., 1992; Schene, 1998)

This permanency planning movement was also evident around the same time (i.e. 1970s-1980s) throughout the United Kingdom. Permanent caregiving placements including adoption were encouraged and contact with the birth family was often discontinued. This changed with the Children Act 1989 which had a significant impact on the role of foster carers (Sellick & Thoburn, 1997). This national legislation for foster care in England and Wales emphasised a shift away from the role of the foster carer as a substitute parent, towards an inclusive approach with birth parents. Local authorities were expected to facilitate enduring contact between the looked-after child and their parents, with the objective of reunification with the birth family when possible (Nutt, 2006; Ward & Munro, 2010). The change in nomenclature from 'foster parent' to 'foster carer' also emphasised this continuing

role of birth parents. Moreover, it recognised the level of skill needed to provide foster care which exceeds that of regular parenting. The increasing complexity of the fostering task has led to debate regarding whether or not foster carers should have a professional status and be paid for their role (Nutt, 2006).

New Zealand has largely paralleled these international developments in foster care. During the 19th century children who were homeless, maltreated, living in poverty, or who committed offenses, were placed in residential institutions or industrial schools. Like other western countries a ‘child rescue’ model dominated child welfare practice. The Children, Young Persons and Their Families Act 1989 saw a major shift in this approach. Its principles promoted a ‘family support’ model (Doolan & Connolly, n.d.). Priority was given to maintaining the relationship between the child and their family. If a child could not stay with primary caregivers/immediate family due to concerns regarding the child’s safety and wellbeing, then placements with extended family/whanau were considered. Funding was allocated to family preservation services to prevent out-of-home placement and to ensure Maori children in particular could remain within their iwi (Maori tribe/extended kinship group (Dalley, 1998). From this legislation came the introduction of Family Group Conferences (FGC) which involves primary and extended family members meeting with professionals to express concerns and who together make decisions regarding care arrangements that ensure the safety of the child (Doolan & Connolly, n.d.).

Foster care today

“At any given time, perhaps a million children in the western world either reside in legally-mandated alternate care, or have been adopted from such care” (Tarren-Sweeney, 2010, p.613). In England, for the year ending 31st March 2014, there were 68,840 looked-after children, of which 75% were in foster care placements (placement with family or non-relative caregiver) (Department for Education, 2014). The most recent statistics from the United States Children’s Bureau reveal that at the end of September 2013, 402, 378 children were in out-of-home placements, of which 47% were in non-relative foster placements, and 28% were in family foster placements (Child Welfare Information Gateway, 2015). The total number of children and young people in out-of-home placements in New Zealand at the end of March 2015 was 4,119, of which 28% were between 5-9 years of age, and 58% were of Maori ethnicity. Non-family placements made up 29% and family placements 51% (Department of Child Youth and Family, 2015d).

Over time there have been substantial changes to the role and status of foster carers. The fostering task today is a more difficult one. Foster carers are now looking after children who were in the past treated in more intense institutional environments (Sinclair et al., 2004). The increased emphasis on providing family support services and intervention to keep children with their biological parents also means that children entering foster care are likely to come from more challenging contexts and have behavioural difficulties of greater severity (Sinclair et al., 2004; Wilson & Evetts, 2006). Moreover, foster carers are expected to be part of the child's therapeutic care team which aims to ameliorate the child's difficulties and promote positive development (Crosson-Tower, 2007). Foster carers work in partnership with social workers, psychologists, and therapists. They do not simply provide a caregiving role; they must also have the skills to manage the complex nature of those children who enter the care system (Crosson-Tower, 2007; Nutt, 2006). The increasingly demanding role of foster care has implications for improvements in support, training and adequate remuneration (Wilson, Sinclair, & Gibbs, 2000).

Overall there has been a major shift away from a child protection approach to a family support approach (Nutt, 2006; Schene, 1998). Today foster care is used as a temporary care arrangement with the aim of returning children to their biological parents when possible (Hacsi, 1995; Nutt, 2006). While this is the stated aim, the reality is that an increasing proportion of children in foster care do not return to their parents' care (Biehal, Ellison, Baker, & Sinclair, 2009). There has also been an increasing trend towards finding kinship placements for children in the care system. The placing of children with relatives is believed to reduce the negative impacts of separation from birth parents and to help preserve family and cultural connections. It is considered to be a less disruptive experience than being placed with strangers, and is therefore given priority (Crosson-Tower, 2007; Hunt, 2009). The use of kinship placements is particularly prevalent in the USA, Australia, New Zealand and Italy (Thoburn, 2009). The New Zealand term for kinship placements is *whanau* (Maori word for 'family') placements. However, throughout this thesis the more recognised term 'kinship' will be used.

The nature of foster care today varies. It depends on the intensity of the problem and reason for the referral. Common reasons for children entering the care system, is risk of abuse (emotional, physical, and sexual) and neglect (Sinclair & Wilson, 2009; Tarren-Sweeney & Vetere, 2014; Thoburn, 2009). Foster care includes short-term care (e.g. emergency care, respite care), intermediate care (e.g. transitional care), and long-term care (Department of Child Youth and Family, 2015c; Sinclair & Wilson, 2009). The outcomes of foster care can

be reunification with the child's birth parents, adoption by the foster family or another family, permanent/long-term foster care or independent living (Pecora et al., 1992). A permanent care option unique to New Zealand is the 'home for life' policy, which is provided as an alternative to adoption. When children in foster care cannot be returned to their parents, a 'home for life' with other family members (i.e. kinship placement) becomes the permanent care goal. When this is not possible a 'home for life' with non-family is sought (Department of Child Youth and Family, 2012). A 'home for life' means that the chief executive (i.e. Child Youth and Family) is no longer the legal guardian of the child. The new caregiver will have legal guardianship in addition to the birth parents (Department of Child Youth and Family, 2010).

Characteristics of children in foster care

Children and young people in care are very likely to have experienced significant adversity including emotional and physical abuse, and deprivation. They are the most socially and developmentally disadvantaged group of young people in the developed world. Moreover, upon entry into care these children experience the loss of their biological parents, the challenging task of having to adapt to a new family, and for some a constantly changing caregiving environment due to placement breakdown (Tarren-Sweeney & Vetere, 2014). It is therefore no surprise that there is an elevated rate of mental health difficulties for children in out-of-home care compared to children in the general population (Rutter, 2000). In fact, as a population, their mental health more closely resembles clinic-referred children, than children at large. The majority of these mental health problems are characterised by attachment difficulties, conduct problems, inattention/hyperactivity, trauma-related anxiety and inappropriate sexual behaviour (Tarren-Sweeney, 2008a).

The high prevalence and severity of mental health problems for children in care has been found across Western countries. Using the ICD-10 (International Classification of Diseases, tenth revision) and DSM-IV (Diagnostic and Statistical Manual, fourth edition), a national study on the mental health of youth (aged 5-17) looked after by local authorities in England, found that 45% of the sample had a mental health disorder. This was four to five times higher compared to a sample of the general population (Meltzer, Lader, Corbin, Goodman, & Ford, 2003). The same national survey conducted in both Scotland and Wales found very similar rates of mental health disorders of 45% and 49% respectively (Meltzer, Lader, Corbin, Goodman, & Ford, 2004a, 2004b).

Sawyer, Carbone, Searle, and Robinson (2007) investigated the prevalence of mental health problems for children aged 6-17 living in foster care in Adelaide, Australia, using the Child Behaviour Checklist (CBCL). The prevalence of mental health problems for this sample of foster children was two to five times higher than that obtained from a National Survey of children and adolescents from the general population. In a prospective epidemiological study of 347 4-9 year old children in foster or kinship care in New South Wales, Australia, the severity of mental health problems resembled those of clinic-referred children (Tarren-Sweeney & Hazell, 2006). These included 'social problems', 'attention problems', 'aggressive behaviour', 'delinquent behaviour', and 'thought problems'. Over half of the boys and half of the girls scored in the clinical range for at least one CBCL scale score. In the same study, scores on the Assessment Checklist for Children (ACC) revealed that approximately one third of the sample displayed age-inappropriate sexual behaviour and most of the children demonstrated behaviours indicative of insecure relationships (Tarren-Sweeney & Hazell, 2006).

Studies in the U.S also report high prevalence rates and severity levels of mental health difficulties for children and adolescents in out-of-home care. In a study of 17-year old adolescents in the foster care system in the U.S state of Missouri, results revealed that 61% qualified as having at least one psychiatric disorder in their lifetime. The prevalence of major depression and PTSD in the study sample was three and two times greater respectively, compared with a community sample of adolescents (McMillen et al., 2005). Similar results were found in the Casey Field Office Mental Health Study (CFOMH) of 188 14-17 year-olds in foster care through the Casey Family Program in the U.S. Results showed that 63.3% had at least one lifetime mental health disorder compared to 45.9% of adolescents in the general population (White, Havalchak, Jackson, O'Brien, & Pecora, 2007). Both studies showed that the highest rates were for disruptive disorders (e.g. conduct disorder), major depression and ADHD (McMillen et al., 2005; White et al., 2007).

Attachment difficulties

Attachment difficulties are common in children in care (Tarren-Sweeney, 2010; Tarren-Sweeney & Hazell, 2006). Children in foster care experience separation from their biological parents, as well as a successive loss of adult caregivers following entry into the care system due to placement breakdown. Moreover, these children have a history of parental abuse and emotional deprivation. These experiences are detrimental to the child's

development of healthy attachment relationships (Golding, 2006b; Tarren-Sweeney, 2008a). These children are at risk of developing insecure and disorganised attachment relationships (Howe & Fearnley, 2003; O'Connor & Zeanah, 2003; Schofield & Beek, 2005). Some may develop a disorder of non-attachment such as a Reactive Attachment Disorder (RAD) as outlined in the Diagnostic and Statistical Manual of Mental Disorders (5th ed; DSM-5). This disorder is “characterised by a pattern of markedly disturbed and developmentally inappropriate attachment behaviours in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, or nurturance” (American Psychiatric Association, 2013, p.266). The other disorder of non-attachment outlined in the DSM-5 is the Disinhibited Social Engagement Disorder, which is characterised by a “pattern of behaviour that involves culturally inappropriate, overly familiar behaviour with relative strangers” (American Psychiatric Association, 2013, p.269).

Children are biologically programmed to seek parental proximity when they feel frightened (Howe, 2009). This is because for most children the caregiver provides a sense of safety and reassurance. If the caregiver is consistently available to provide this care and responsivity at times of need, the child is likely to develop a secure attachment. For many children who enter the care system due to instances of abuse and maltreatment, their caregivers are the source of fear (Howe, 2009). Consequently, these children experience conflicting behavioural responses: approach the caregiver/attachment figure for safety and avoid the caregiver to escape danger. This makes it very difficult for the child to organise an attachment strategy, leading to attachment-disordered behaviours (Howe, 2009; Howe & Fearnley, 2003).

As a result of being subjected to parental abuse and neglect, these children are likely to develop internal representations of dangerous, rejecting and abandoning caregivers. They may also establish a sense of self that is unworthy, unlovable and under threat (Howe & Fearnley, 2003; Schofield & Beek, 2005). As a survival mechanism, these children then develop adaptive strategies characterised by aggression, control, avoidance and/or suppressed affect (Howe & Fearnley, 2003). Children bring with them to foster care these established mental states and behavioural strategies, making it difficult for them to respond to and accept the affection and sensitive caregiving they receive in their new out-of-home placement (Stovall & Dozier, 1998).

Children who have experienced maltreating environments may view their new carers with suspicion and distrust. The sensitive caregiving demonstrated by foster carers may appear to the child as devious behaviour (Schofield & Beek, 2005). Foster carers are faced

with the challenge of trying to provide loving and responsive care while often feeling rejected, unwanted and/or inadequate. For example, those children who have experienced a severely neglectful caregiving environment are likely to have developed exaggerated attention-seeking behaviours in order to increase the likelihood that they will be responded to by adult caregivers. In the new foster placement these children will continue to exhibit these behaviours. As a result, carers can feel helpless as they are unable to soothe the child and meet their emotional needs, leading to exhaustion and discouragement (Howe, 2009). To provide another example, an abused child may have developed strategies of avoidance and self-reliance. In response to these behaviours the new caregiver might feel unwanted and subsequently reduce their levels of sensitivity and affection. In this way the child is eliciting responses from their foster carer that are congruent with their expectations. That is, caregivers are a source of neglect rather than security (Howe & Fearnley, 2003). It is crucial that caregivers receive adequate information about attachment difficulties to prevent these detrimental child-caregiver transactions (McDonald, 2011).

Research shows that a younger age at entry into care is a protective factor against the development of mental health problems (Tarren-Sweeney, 2008b). Age at entry into care is a general indicator of the length of time a child is exposed to adversity. Later-placed children are more likely to have been chronically maltreated over several years in comparison to infants and younger children entering the care system (Tarren-Sweeney, 2008b). It has been shown for infants aged between 12 and 24 months that their attachment systems are flexible and can change to be congruent with the attachment style of their new foster carer (Dozier, Stoval, Albus, & Bates, 2001). For those later-placed children however, their attachment systems are more resistant to change. These children are likely to have internal representations of the self and other that are more ingrained. There is evidence that beyond infancy (7-months of age), there is a linear deterioration in a child's mental health including attachment disorder behaviours, with increasing age at entry into care (Tarren-Sweeney, 2008b).

A risk factor for the development of mental health problems for children in care, including attachment difficulties, is placement instability (Delfabbro & Barber, 2003; Tarren-Sweeney, 2008b). Frequent placement turnover is detrimental to a child's developmental recovery and limits their ability to form stable attachments to adult caregivers (Tarren-Sweeney, 2008a, 2008b). Foster carers require support and training to help promote the stability of placements, in particular for those foster children that have attachment- and

trauma-related difficulties where the development of lasting attachments is crucial (Murray, Tarren-Sweeney, & France, 2011).

Placement instability

Placements can breakdown for a number of reasons including family tensions, difficulties around contact with the birth family, a foster child's behavioural difficulties, and the child feeling unhappy in their placement (Farmer et al., 2004; Sinclair et al., 2004). Farmer et al. (2004) conducted a one year longitudinal study of adolescents placed in a new medium-long-term foster care placement, and found that 40% of these disrupted within that year. In another study, Sinclair (2005a) found that for their sample of 11-14 year olds, 48% had experienced at least one placement disruption within a 3 year period.

Moving frequently between placements can be very unsettling and frightening for foster children (Sinclair, 2007). Moreover, a placement breakdown can be emotionally difficult for both the foster child and carer who grieve for their loss. Placement changes can however be beneficial for the child if their purpose is to achieve greater stability without further disruption. The child may move to an adoption placement or move back to their birth family. How these placement changes impact the child depends on various factors including the child's age and characteristics, and their time already spent in the care system (Sinclair, 2007). Stability is a valuable outcome that needs to be achieved. As discussed above, children often enter foster care with attachment difficulties. These difficulties are likely to be exacerbated with frequent placement moves. In a study of pre-adolescent children in foster and kinship care in New South Wales, Tarren-Sweeney (2008b) found that indicators of placement security and/or permanency predicted children's mental health problems. The author hypothesised that attachment security was the underlying mechanism accounting for this relationship. That is, the child's perception of permanence in the placement may directly influence their attachment security. Further, the carer's perception of placement permanency influences their own attachment systems which in turn can influence the attachment security of the child (Tarren-Sweeney, 2008b).

The link between placement instability and poor mental health has been well established in the literature (Tarren-Sweeney, 2008b). Results from several studies indicate a bidirectional relationship between placement breakdown and child behavioural difficulties. That is, the behavioural difficulties of children in care are both the cause and the consequence of placement breakdown (Delfabbro & Barber, 2003; Newton, Litrownik, & Landsverk,

2000). Newton et al. (2000) conducted a prospective study on the relationship between change in placement and problem behaviours over 12 months for a sample of 415 children in foster care. They found that the number of placement changes strongly predicted an increase in internalising and externalising behaviour after controlling for initial levels of behaviour problems. Moreover, externalising behaviour problems were found to be the strongest predictor of later placement changes (Newton et al., 2000). Delfabbro and Barber (2003) found similar results. Children of an older age with more severe levels of conduct problems and mental health issues were at a greater risk of experiencing an early placement breakdown. Results also revealed that sustained placement instability predicted deterioration in a child's emotional and social adjustment (Delfabbro & Barber, 2003). These findings have strong implications for the provision of adequate support and training for foster carers to ensure they have the resources to manage a child's behavioural and emotional difficulties. This could help to prevent the negative cycle of placement breakdown and deterioration of a foster child's mental health.

The challenges of providing foster care

Becoming a foster carer is life-changing. Carers must adapt to drastic changes in their everyday routines and activities. Almost all realms of a carer's life are impacted by their new role as a foster carer (Nutt, 2006). While foster care can be very rewarding and bring great satisfaction to a foster carer's life, it is also an extremely challenging role (Sinclair et al., 2004). Foster carers must deal with the demands of children who have difficult and complex symptomology. This is compounded by what is perceived to be a complex and rather ambiguous role (Nutt, 2006). This section looks at the challenges and negative impacts of fostering, which are found to be similar across different international contexts. The burden of care highlights the importance of appropriate support and training for foster families.

Ambiguous and complex role. The role of foster carers can be described as quite ambiguous and complex. Their task is to provide a nurturing environment for their foster child, to make them feel welcomed into their family, and to help build a secure attachment system. Foster carers assume many of the same roles as a parent yet they are relatively powerless (Nutt, 2006). Foster care invades almost every realm of life, yet carers have almost no autonomy of care. They must recognise the parental rights of the birth family and adhere to the rules and regulations of their local authority. Public bureaucratic structures intrude on the private lives of foster carers. For example, the home must be open for visits from social

workers and inspections. This intrusion by the state infringes on natural family rights, and would not be condoned by families at large in a modern, democratic society. It is difficult to take on the formal role as carer while at the same time provide the informal and natural experiences of an 'ordinary' family life (Nutt, 2006).

With the passing of the Children Act 1989 in the United Kingdom (UK), there has been a shift towards a partnership between foster carers and birth parents (Nutt, 2006). This complicates the task of fostering in many ways. It is difficult for foster carers to know where to draw the boundaries. Foster carers want to provide their foster child with what they don't have. That is, a parent in a loving home environment. But it is not their role to replace the child's biological parents (Nutt, 2006). It then becomes difficult for foster carers to know the extent to which they should become emotionally involved in the child's life and whether to allow themselves to form attachments (Farmer et al., 2004).

A foster carers' identity is complex. They are a parent to their own biological children but a carer to the foster child. While the aim is to create a sense of belonging and equality for the foster child within their new family, in practice this is very difficult. There can be anxiety around bureaucratic surveillance which results in foster carers having to treat their biological children differently to their foster children, and this can be a difficult balancing act (Nutt, 2006).

In the UK study by Nutt (2006) carers positioned themselves as powerless, undervalued and often exploited. The majority of carers viewed the local authority in a negative light. Rather than feeling like part of the team, they felt distanced, mistrusted and unsupported. Carers described having little say regarding the decisions made even when they had a significant impact on their own personal lives.

Social impact: friendships, lack of understanding, judgment. Foster care can have a significant impact on a carer's social life. Foster carers can feel rejected by their friends who are often unsupportive of their new role (McDonald, 2011; Nutt, 2006). Carers describe not being invited to friends' places due to the foster child's disruptive behaviour. Moreover, friendships can be negatively impacted by the foster child's inappropriate behaviour towards the friends' own child. For some, past friends are estranged in favour of new friends who are often foster carers themselves and are therefore more understanding of their circumstances and their new foster carer status (McDonald, 2011; Nutt, 2006). Fostering can also impact on the quality of friendships. Instead of being open and honest with their friends, new boundaries must be drawn to ensure information about their foster child remains confidential (Nutt, 2006).

A lack of understanding by professionals, friends, and family regarding the foster child's difficulties, can lead to foster carers feeling hurt, frustrated and isolated. This lack of understanding can result in scrutiny and judgment by others, which can exacerbate the stress foster carers already experience in their role (McDonald, 2011). Foster carers can feel personally blamed for their child's difficult behaviour. In a study by Farmer et al. (2004) with foster carers from England, over a third of the sample reported experiencing criticism or hostility from others for being a foster carer. The majority experienced this criticism from their neighbours who believed the foster carer was unable to adequately manage the foster child's behaviour and who disliked living next door. Some of the carers had even been criticised by members of their own family for letting fostering consume their lives (Farmer et al., 2004).

Emotional impacts. In the study by Nutt (2006), the majority of carers found themselves caring for and loving their foster child in very similar ways to their own biological children. Becoming too emotionally involved however puts the carers in a vulnerable position. "Foster carers are expected to love and let go" (Nutt, 2006, p.53). Placement breakdown can be a very emotional time for foster carers and their biological children as they experience a significant amount of grief and mourn for their loss (Nutt, 2006; Sinclair et al., 2004; Younes & Harp, 2007). In a U.S study, biological children reported that the removal of the foster child from their home was like losing a sibling (Younes & Harp, 2007).

In a New Zealand study conducted by McDonald (2011), some of the foster carers described how they had formed attachments to their foster child and become emotionally invested, but that these were often one-sided relationships. Such experiences as well as their expectations of loss, led to some carers putting up an emotional boundary between themselves and the child as a deliberate protective mechanism. In the study by (Nutt, 2006) foster carers described wanting to protect themselves through detachment. At the same time, their love for the child as if they were their own, and desire to give what the child needed, invoked attachment. This created a difficult emotional dilemma (Nutt, 2006). Foster carers can also feel a sense of futility when they invest so much of their resources into the foster child and see very little improvement over time (Sinclair et al., 2004). They may experience feelings of guilt and self-blame when the child does not succeed in ways they had hoped (Nutt, 2006).

Impacts on family. Foster care impacts the entire family. It can lead to a major shift in family structure and roles which may require a considerable period of adjustment (Younes

& Harp, 2007). In the study conducted by Sinclair et al. (2004), approximately one third of their sample of foster carers from England experienced severe family tensions as the result of a difficult placement. It can be particularly challenging for foster families who are also parenting their own biological children. Given the demanding nature of fostering, carers have less time to spend with their own children. The attachment difficulties of foster children can also negatively impact the quality of affection and responsiveness carers provide for their own children (McDonald, 2011).

Some biological children can find it difficult to accept the foster child into their family. They can become jealous, angry, withdrawn and more demanding of the parent's time (Sinclair et al., 2004; Younes & Harp, 2007). In the U.S study by Younes and Harp (2007), biological children reported experiencing difficulties with having to share their parents' time and affection with the foster children, as well as observing how much stress fostering was causing their parents. Other studies also report how biological children can be subjected to bullying, theft and violence by the foster child (McDonald, 2011; Sinclair et al., 2004). When the placement negatively impacts the wellbeing of the biological children in this way, it is very likely that the placement will breakdown (Farmer et al., 2004). In the study by Nutt (2006) most carers described loving their foster child as if they were their own but could not treat them the same as their biological children due to risk of allegations. In order to achieve parity, changes in caregiving were made, and it was often the birth children who experienced detrimental alterations in the way they were parented. Some foster carers also described how social services failed to take into account their whole family; the foster child took precedence with little consideration of how family members could be impacted (Nutt, 2006).

Challenges of continuing contact with birth parents. Foster carers often describe difficulties with having to maintain contact with the foster child's birth parents (Hashim, 2009; McDonald, 2011; Nutt, 2006; Sinclair et al., 2004). These difficulties can include birth parents not showing up reliably to the arranged visits, demonstrating persistent rejection towards the foster child, and displaying behaviours which cause the visit to be unsafe (Farmer et al., 2004). Sinclair et al. (2004) found that approximately one quarter of foster carers in their study experienced difficulties with birth parents. Foster carers described coming into contact with birth parents who were aggressive, argumentative, and even threatened physical violence. These experiences can often lead to placement breakdown (Sinclair et al., 2004).

Contact difficulties with the foster child's birth parents can put the foster family under a considerable amount of strain. Levels of strain as measured on the GHQ have been found to be substantially higher for those foster carers experiencing these contact difficulties. Often

foster children act-out after the visit with violent and disruptive behaviours that can be distressing for the whole foster family (Farmer et al., 2004). In a New Zealand study conducted by Hashim (2009), which looked at the contact between children in care and their birth families, foster carers reported that the foster child's behaviour prior to and after the visit appeared to be more aggressive and defiant, and some were more fearful and insecure. It was a stressful time for carers. They were concerned that these visits would lead to their disempowerment and be unsettling for the child (Hashim, 2009). Findings from a systematic review on contact with birth parents, revealed that contact often led to the reactivation of insecure attachment behaviours in foster children, as well as aggressive behaviour and ambivalent feelings towards their foster carers (Boyle, 2015).

Stress and strain: its impact on fostering. Foster carers often experience high levels of stress. This can be attributed to a range of factors including difficulties communicating with social workers, the challenges of dealing with the child's biological parents, family tensions, abuse allegations, and placement breakdown (Wilson et al., 2000). The challenge of managing the foster child's severe emotional and behavioural symptomology is also a commonly cited source of stress for foster carers and their family (Buehler, Cox, & Cuddeback, 2003; Jones & Morrisette, 1999; Morgan & Baron, 2011; Murray et al., 2011). One particular study conducted in England, found that 54% of their participating sample of foster carers had scores on the Parental Stress Index (PSI) in the borderline or clinical range. Results from this same study also revealed a positive association between foster children's challenging behaviour and foster carers' level of stress, anxiety and depression (Morgan & Baron, 2011). There is evidence that a carer's experience of significant stress can impact on the quality of care they provide and the overall success of the foster placement. This has implications for the provision of services which provide appropriate support to maintain foster carers' own wellbeing and their therapeutic potential (Farmer et al., 2004; Sinclair et al., 2004).

Sinclair et al. (2004) conducted a study with 950 registered foster carers from seven local authorities in England. Results of the study revealed how the severe behavioural difficulties of the foster child placed a significant amount of strain on the foster family, and that these severe family tensions often led to placement breakdown. This placement breakdown itself was in fact the most commonly experienced stressful event reported by foster carers in the study. It can be a very stressful time due to the cumulative impact of the many distressing events from which the breakdown resulted. It is often the case that carers have reached their breaking point by the time the placement ends. The experience of these

and other stressful 'events' were significantly associated with less positive attitudes towards foster care and their intention to give up fostering in the future (Sinclair et al., 2004).

Farmer et al. (2004) investigated the level of strain experienced by foster carers of adolescents and the impact this had on their caregiving strategies and placement outcomes. Foster carers participating in the study were referred by fourteen local authorities and two independent fostering agencies in England. At the initial assessment (three months of child in placement), approximately one third of carers had total scores on the General Health Questionnaire (GHQ) in the subclinical or clinical range. 38% scored in the subclinical and clinical range for anxiety symptoms at the initial assessment which rose to 48% at follow-up (nine months). In the domain of social functioning, 81% scored in the subclinical and clinical range at the initial assessment and 98% scored in this range at the nine month follow-up. This indicated that carers were not enjoying typical daily activities and were not functioning well on a day to day basis. Foster children who had carers with social difficulties, demonstrated less improvement in their well-being during their time in the placement. The study also revealed that those foster carers who experienced strain during the placement demonstrated parenting characterised by lower levels of sensitivity, and were more likely to feel a disliking towards their foster child, both of which predicted subsequent placement disruption. Foster carers who felt strained were rated as being less committed to the child and showed lower levels of engagement (e.g. support and concern) with the foster child. They also made less effort in ensuring the child received adequate services (e.g. counselling) (Farmer et al., 2004).

Foster care support

The burden that comes with providing foster care clearly demonstrates how important it is that carers receive effective support. Further evidence for the importance of support comes from studies which have identified that a lack of support, as perceived by foster carers, is a major factor contributing to carers ceasing to foster (Rhodes, Orme, & Buehler, 2001; Sinclair et al., 2004; Triseliotis, Borland, & Hill, 1998). The types of support carers receive can be divided into two broad categories: informal and formal. Sources of informal support include family, friends and other carers. Formal support can include training, respite, and social worker support (Sinclair et al., 2004). In their definition of support, Nixon (1997) emphasises the importance of having a combination of both these informal and formal support structures which are inclusive of professional, social and personal elements. Several studies conducted across different countries, have investigated the types of support and

services carers believe to be important in facilitating their fostering role, and whether these are currently being provided and are of an adequate quality.

Informal support. Foster carers across several different studies have identified other carers as being an important source of support. This can be in the form of caregiver support groups and/or individual caregiver connections (Department of Child Youth and Family, 2007; Farmer et al., 2004; Murray et al., 2011; Sinclair et al., 2004). Foster carers describe the value in receiving information and advice from other caregivers who are experiencing similar issues to themselves (Farmer et al., 2004; Maclay, Bunce, & Purves, 2006; Murray, 2007). In an Australian study, Octoman and McLean (2014) found that approximately half of their foster carer sample rated current foster carers as being the best people to deliver support concerning the behavioural issues of foster children. In the study by Sinclair and colleagues (2004), with foster carers in England, approximately 70% of the sample rated other foster carers as being a useful and regularly available source of support.

In addition to the sharing of their relevant knowledge and skills, other foster carers are valued as being a receptive and more understanding audience to whom carers can vent their frustrations and concerns (Murray, 2007; Wells, 2004). For some foster carers, family members and friends are not sought for support given their lack of understanding for what they are experiencing and appreciation for the commitment they have made to the foster child (Nutt, 2006; Wells, 2004). Contradictory to this, foster carers in other studies describe their family to be an important source of support (Department of Child Youth and Family, 2007; Farmer et al., 2004; Sinclair et al., 2004). Sinclair and colleagues (2004) found that foster carers rated their family (63%) and other relatives (24%) as providing ‘a lot’ of support. Moreover, foster carers receiving support from their own biological children, has been found to be associated with more successful placements (Farmer et al., 2004).

Support from caseworkers/child welfare workers. Studies investigating foster carers’ perceptions of support commonly identify the responsiveness, availability and communication of social workers as being highly valued; however these are often described as being of an unsatisfactory standard. Foster carers describe several issues with social worker support, these include: not responding promptly to phone calls and requests, lack of communication, lack of recognition and respect for their opinions and role, unavailability, and infrequency of visits (Cavazzi, Guilfoyle, & Sims, 2010; Farmer et al., 2004; Fisher, Gibbs, Sinclair, & Wilson, 2000; Hudson & Levasseur, 2002; MacGregor, Rodger, Cummings, & Leschied, 2006; Murray et al., 2011; Sinclair et al., 2004; Triseliotis, Borland, & Hill, 2000; Wells, 2004). These issues have been found to be associated with carers

experiencing increased levels of strain, greater difficulties with caring for their foster child, and thoughts about giving up fostering (Farmer et al., 2004; Triseliotis et al., 2000).

Foster carers also express the importance of there being a partnership between themselves and the agency workers. Carers want to be respected by professionals as a valuable member of the care team, contribute to decisions regarding their foster child, and be recognised as experts in their own right. Carers value workers who listen to and respect their views (Cavazzi et al., 2010; Farmer et al., 2004; Fisher et al., 2000; Hudson & Levasseur, 2002; MacGregor et al., 2006). Across several studies, foster carers have reported that these qualities and aspects of support are often lacking (Cavazzi et al., 2010; Farmer et al., 2004; Fisher et al., 2000; Maclay et al., 2006). When foster carers are not involved in the decision-making process, it can make them feel as though they are merely a “babysitting service rather than an integral part of the child’s life” (Cavazzi et al., 2010, p.133). In their study with a sample of foster carers in England, Farmer et al. (2004) found that just under half of the carers found that their views were taken seriously only sometimes or not at all, and this was associated with increased levels of strain.

Another problematic area identified by some foster carers, is the lack of sufficient information provided by social or other agency workers regarding their foster child’s background such as basic health information and the nature of their behavioural difficulties, as well as information on the child’s care plan (Cavazzi et al., 2010; Department of Child Youth and Family, 2007; Farmer et al., 2004; Fisher et al., 2000; McDonald, 2011; Murray et al., 2011; Triseliotis et al., 2000). This can compromise the quality of care that a carer provides which is developmentally appropriate and sensitive to the child’s level of need (Cavazzi et al., 2010; Gilbertson & Barber, 2003). It can also contribute to foster carers feeling disrespected, used, and unacknowledged (Cavazzi et al., 2010; Maclay et al., 2006). In an Australian study by Octoman and McLean (2014), having relevant and accurate information about a foster child’s behaviour prior to the start of placement, was identified by foster carers, irrespective of their experience level and type of care they were providing (long-term or short-term), as being the most useful form of support that foster carers could receive.

Respite care and crisis intervention. Another useful form of support identified by foster carers is respite care (Department of Child Youth and Family, 2007; Hudson & Levasseur, 2002; MacGregor et al., 2006; Octoman & McLean, 2014; Wells, 2004). Carers report their need for an occasional break away from their foster child/ren to ensure the wellbeing of themselves and their own biological family (MacGregor et al., 2006; Wells,

2004). Respite care has been described by carers as an important and effective formal support service that should be automatically included within the caregiving plan rather than individually requested for (Wells, 2004). Finding casual baby-sitting services can be very difficult given the nature of the child's difficulties and when the carer looks after more than one foster child (Murray et al., 2011). Some carers however, express concerns that respite care may be detrimental to the foster child's sense of permanency and integration within the family (Hudson & Levasseur, 2002). Moreover, respite care can be disruptive for the foster child and lead to increases in their difficult behaviour which in turn can put more strain on the family (Wells, 2004).

Across several studies, crisis assistance or 'out-of-hours service' has also been identified as an important source of support for particularly difficult child behaviour or crisis situations (Farmer et al., 2004; Hudson & Levasseur, 2002; MacGregor et al., 2006; Octoman & McLean, 2014). This can include the involvement of a specialist team, a placement worker, or a general emergency duty team that can be available on call (Farmer et al., 2004). In one particular study carers' satisfaction with out-of-hours services was found to be associated with their feelings of being well supported overall (Farmer et al., 2004).

Training and therapeutic interventions. Training programmes for carers aim to maximise their therapeutic potential and increase placement stability (Tarren-Sweeney, 2014). They generally aim to teach carers effective skills at managing difficult child behaviour, improve carers' understanding of their child's needs and why they behave in certain ways (psycho-education), and improve the child-carer relationship (Golding, 2006a; Kinsey & Schlösser, 2013). Training can be categorised into pre-service and in-service. In-service training targets existing carers, whereas pre-service training is provided for prospective carers (Festinger & Baker, 2013). Further, there is also a distinction between training that is provided for carers in general and those with the purpose of providing a therapeutic service for carers having difficulties with a particular child. Some are applied in both contexts. However, a lack of discussion around this distinction is a limitation of the existing literature (Tarren-Sweeney, personal communication). A lot of carer training programmes use a group format (delivered to groups of carers) led by trained facilitators, allowing carers to share their experiences and listen to those of other carers. They also typically involve multiple sessions (Festinger & Baker, 2013; Golding, 2006a; Kinsey & Schlösser, 2013). There are a range of theories which can underpin these training programmes, such as Behavioural/ Social Learning Theory, Cognitive-Behavioural, and

Attachment Theory (Golding, 2006a). Some programmes draw exclusively on one while others integrate multiple.

Behavioural models focus on how environmental factors trigger and maintain patterns of behaviour. An important guiding principle is that behaviour is learned but can be unlearned by modifying its environmental antecedents and consequences (Bachmann et al., 2011; Golding, 2006a; Turner, Macdonald, & Dennis, 2009). Social Learning Theory (SLT) originated from these principles of behaviourism but also places emphasis on the social context. According to this theory, in addition to behavioural contingencies behaviour can be learned through the observation and modelling of others (Bachmann et al., 2011; Golding, 2006a). Training programmes underpinned by SLT assume that changes in caregiving skills will lead to changes in child behaviour (Golding, 2000). They typically teach positive parenting practices such as praise and positive attention, and non-aggressive discipline strategies (Golding, 2006a). An important rationale for teaching carers the principles of SLT is to minimise coercive child-carer interactions in which the negative and undesirable responses between the child and carer escalate, and are ultimately reinforced and maintained. The child's negative expectations about caregivers may also be reinforced. Carers may be unaware that they are being pulled into these negative interactions with their child. This not only leads to a continuation of problematic child behaviour but also an unhealthy child-carer relationship which in turn increases the risk of placement breakdown (Golding, 2006a; Nilsen, 2007).

Cognitive-Behavioural approaches place additional emphasis on the internal events that impact on behaviour. Along with principles of behavioural theory, CBT also takes into consideration the role of cognitions and how altering one's thoughts can lead to changes in their behaviour (Beck, 1995). Techniques might involve encouraging foster carers to monitor and challenge negative, dysfunctional thoughts about their child or themselves and to replace these with more positive, realistic ones (Bachmann et al., 2011; Turner et al., 2009). They may also focus on understanding how past experiences can influence current behaviour (Turner et al., 2009).

Training programmes based on Attachment Theory focus on how the behaviour of foster carers and the caregiving environment they provide, can be altered to improve the attachment system of the child. This may involve a component of psycho-education on Attachment Theory, including the development of different attachment styles, and the impact that abuse and trauma can have on a child's attachment. Additionally, it can involve the teaching of skills and understanding necessary for carers to respond appropriately and

sensitively to the child to achieve emotional attunement (Allen & Vostanis, 2005; Golding, 2006a; Golding & Picken, 2004; Laybourne, Andersen, & Sands, 2008).

Carers view training as an important source of support (Hudson & Levasseur, 2002; Murray et al., 2011; Octoman & McLean, 2014; Sinclair et al., 2004). However, several studies investigating foster carers' perceptions and experiences have identified several issues and unmet needs in relation to foster carer training (Department of Child Youth and Family, 2007; Farmer et al., 2004; Hudson & Levasseur, 2002; MacGregor et al., 2006; Ogilvie, Kirton, & Beecham, 2006; Sinclair et al., 2004; Wells, 2004). When asked how training could be improved, foster carers have suggested that training content should include more specialised topics in order to be more applicable to the specific needs of their particular child. Suggested topics have included sexual abuse, fetal alcohol syndrome, mental health problems, and autism (Hudson & Levasseur, 2002; MacGregor et al., 2006; Wells, 2004). Moreover, Ogilvie et al. (2006) argued that training needs to be tailored to fit the specific skill and experience levels of foster carers. Foster carers from their study conducted in England, described training as being inadequate for the more experienced carers who wanted to continue to develop and enhance their fostering skills beyond the content provided in the available training courses.

Across several studies, skills for managing foster children's behavioural difficulties has been identified by foster carers as an area of priority for training programmes (Department of Child Youth and Family, 2007; Hudson & Levasseur, 2002; Murray, et 2011). In the study by Murray et al (2011), with foster and kinship carers residing in Canterbury, New Zealand, majority of the participants indicated that they would like further training around difficult child behaviours, including the impacts that trauma/neglect and a disrupted attachment have on a child's behaviour and development, how to promote secure attachments with their foster child, and patterns of normal and abnormal development (Murray et al., 2011). Foster carers have also suggested that training programmes should place greater emphasis on encouraging the participation of carers themselves to provide support and share with others their invaluable knowledge they have gained through practical experience (MacGregor et al., 2006; Octoman & McLean, 2014; Sinclair et al., 2004).

There appears to be no set guidelines on policy and procedures regarding training. That is, there is no model of foster carer training. This is in relation to frequency (how often carers should attend training), content, and whether or not it is compulsory. These issues seem to apply to both pre-placement and ongoing forms of foster carer training (Ogilvie et

al., 2006; Sinclair et al., 2004; Triseliotis et al., 2000). There is substantial variability in these aspects found across agencies and in different countries.

In the study by Sinclair et al. (2004) with foster carers in England, pre-placement training varied from 0 to 200 hours and 21% of the participating sample of foster carers had received no pre-placement training at all. The proportion of carers undergoing further training once the placement had started, also varied greatly, from none at all to more than 50 hours. One quarter of carers had received no training since the start of the placement. Overall, the authors concluded that majority of the carers did not receive intensive training (Sinclair et al., 2004). In the study by Triseliotis et al. (2000), with foster carers in Scotland, one in every six carers reported not being provided with any form of ongoing training. Moreover, of those carers who did have access to ongoing training, approximately one in ten never attended. In a smaller study with foster and kinship carers in Canterbury, New Zealand, Murray (2007) found that only 58.8% of the participants had completed the induction training provided by Child Youth and Family (CYF; New Zealand government agency for child protection). Further, 29.4% of the participants had not completed any of the eight National training modules developed by CYF and the New Zealand Family and Foster Care Federation (NZFFCF). The requirements for pre-placement/pre-service training and in-service training, in the United States, vary between states. Pre-service training can vary from none at all in some states to 30 hours in others. In-service training can vary between none at all to 20 hours per year (Grimm, 2003).

Studies have identified a set of common themes in relation to the issues foster and kinship carers come across in accessing and attending relevant training. These include difficulties with 1. Childcare: finding people who are qualified to care for children with high needs and issues with childcare costs. 2. Timing of training: inconvenient e.g. clashes with work commitments 3. Location: transport difficulties for training courses held out of town 4. Relevance of content material: not relevant to their current needs (Department of Child Youth and Family, 2007; Farmer et al., 2004; Murray et al., 2011; Ogilvie et al., 2006; Sinclair et al., 2004).

Chapter 2: Literature Review

A systematic review of the literature was carried out to identify studies which have evaluated the effects of training programmes for carers. The review aimed to evaluate the evidence base for these training programmes; and to identify their core components, the key trends regarding the effects of these programmes, limitations of these studies, and gaps within the literature. The purpose of describing other training programmes and their evidence base is to provide the reader with a sense of the field in general. Further it provides the reader with context necessary to understand where the Fostering Changes programme fits in relation to other training programmes. Given that Fostering Changes is the focus of the current thesis project the evidence base for this particular programme will be described and critically appraised in greater detail.

Selection Criteria

Inclusion: This review focusses on in-service training programmes only. Further, it specifically includes those in-service training programmes which directly target carers and use a group format. *Exclusion:* It therefore excludes one-on-one interventions with the carer, relational interventions (i.e. carer-child dyad), interventions with the foster child only, and wraparound interventions. Moreover, the review excludes training programmes which are designed for adoptive parents; this was not the population of interest for this study.

Search Strategy

Searches were made within the following electronic databases: PsychInfo, CINAHL, Google Scholar, EBSCOhost, California Evidence-Based Clearinghouse for Child Welfare, and the Cochrane library. Individual searches were also carried out within specific journals including Adoption and Fostering, Clinical Child Psychology and Psychiatry and the Journal of Clinical Child & Adolescent Psychology. Searches used the following search terms, which were combined in different ways using Boolean search operators (* indicates truncation): foster parent*, foster care*, foster home*, foster mother*, foster father*, kinship care*, program*, intervention*, stud*, train*. The following search fields were also used: foster care, foster parents, program evaluation, and educational program evaluation. Several systematic reviews were found and their reference lists were checked to identify any studies that had been missed in the search.

Outline

The first section of this literature review outlines individual studies of training programmes for carers. These studies do not provide a body of research-based evidence on one particular training programme. Rather, they are ‘one-off’ studies, each which evaluates a different programme. It is therefore difficult to coalesce these findings. For this reason only those studies which were published 2000 or later were included. Following this, the review outlines the evidence base for three different training programmes: Fostering Attachments, KEEP (Keeping Foster and Kinship Parents Trained and Supported), and Fostering Changes. Each of these programmes has been evaluated by several different studies.

All of the studies described assessed at least one of the following: child-related outcomes (behavioural difficulties, emotional difficulties, and attachment), carer-related outcomes (satisfaction with training, confidence, self-efficacy, knowledge, understanding, responses to behaviour, stress, and caregiving skills), child-carer relationship, and placement stability. Majority of the studies used carer-rated quantitative measures to assess these outcomes.

‘One-off’ studies of training programmes for foster carers

Four of the identified ‘one-off’ studies evaluated training programmes that were based on cognitive-behavioural and SLT principles (Herbert & Wookey, 2007; Hill-Tout, Pithouse, & Lowe, 2003; Macdonald & Turner, 2005; Nilsen, 2007). Three studies evaluated programmes that were based on, or incorporated, Attachment Theory (Allen & Vostanis, 2005; Holmes & Silver, 2010; Minnis, Pelosi, Knapp, & Dunn, 2001)

Training programmes based on Cognitive-Behavioural and/or Social Learning principles. The different training programmes evaluated in the studies below, all focussed on increasing carers’ understanding and management of children’s behavioural difficulties, and investigated whether this would lead to improvements in child- and carer-related outcomes. Two studies reported on Randomised Controlled Trials (RCTs) (Herbert & Wookey, 2007; Macdonald & Turner, 2005) one on a quasi-randomised controlled trial (Hill-Tout et al., 2003) and one on a non-randomised controlled trial (Nilsen, 2007).

Hill-Tout et al. (2003) conducted a quasi-randomised controlled trial with 106 foster carers in South Wales (53 in each of the control and intervention group). The training programme was delivered over three days to groups of approximately 15 carers. Data was collected before training and approximately five weeks post-training. The authors concluded

that the training had a limited impact on child behaviour and carer-related outcomes. No statistically significant (quantitative) differences were found between the intervention and control group at either time point, in regards to the frequency and severity of children's presenting behaviours, in carers rated level of stress, their emotional responses to challenging behaviours, and in their analytic understanding of their child's behaviour. In contrast to these findings, carers' ratings on a satisfaction questionnaire revealed that majority showed strong approval for the programme. No negative ratings were given. Carers were very satisfied with the programme and had started to apply the skills taught (Hill-Tout et al., 2003).

Macdonald and Turner (2005) conducted an RCT with 117 foster carers from local authorities in England, who were randomly allocated to either a CBT-based training group (four weekly, five-hour sessions), or a waitlist control (standard services). In addition to cognitive and behavioural principles, the training also focussed on understanding the impact of children's early caregiving experiences, and the specific difficulties carers can experience looking after a foster child. Data was collected before and directly after training, and at a six-month follow-up. Similar to the findings from Hill-Tout et al. (2003), no statistically significant (quantitative) differences were found between the two groups post-training or at follow-up in regards to the frequency and severity of child behavioural problems. This was also the case for the number of unplanned placement breakdowns. Despite this, carers in the CBT group scored significantly higher post-training in regards to their knowledge of behavioural principles, and ratings indicated that overall they were satisfied with the programme. Further, during interviews carers reported having an increased confidence in their skills to manage their child's difficult behaviour (the study does not specify whether this was found directly after training and/or at follow-up) (Macdonald & Turner, 2005).

Herbert and Wookey (2007) investigated whether foster carers' participation in the Child Wise Programme (CWP) would improve carers' confidence and skills in behavioural management, subsequently leading to a reduction in their children's challenging behaviours and the unplanned breakdown of placements. The CWP is a CBT-based intervention that was originally developed for birth parents. An RCT was conducted with a sample of 117 foster carers from six local authorities in England, who were randomly allocated to a waitlist control (n=50) or training group (n=67). The CWP was delivered to groups of approximately 12 carers and consisted of four weekly, five-hour sessions. Data was collected before and directly after the training programme. Consistent with the findings from the above two studies, no statistically significant (quantitative) changes were found between the two groups

regarding children's behavioural problems, and in the number of unplanned placement breakdowns (Herbert & Wookey, 2007). Despite these findings, interview data revealed that majority of carers in the training group had observed improvements in their child's behaviour as a result of the programme. Further, those carers in the training group scored significantly higher than the control group in regards to their knowledge of behavioural principles. Majority of the carers in the training group indicated that they were very satisfied with the training, that they would recommend it to others, and that their confidence in their caregiving abilities had increased (Herbert & Wookey, 2007).

In all of the above three studies carers were very satisfied with the training they had received. Further, two of the studies found increases in carers' knowledge of behavioural principles and confidence in their ability to manage their child's challenging behaviours (Herbert & Wookey, 2007; Macdonald & Turner, 2005). However, consistent across all three studies was a lack of significant measurable change in children's behavioural problems. The authors suggest possible explanations for this lack of measurable effect. Macdonald and Turner (2005) state that training carers in cognitive-behavioural methods is not sufficient on its own to bring about such change given the severity of these children's behaviours for which more specialised support is required. Hill-Tout et al. (2003) identified that majority of the children included in their study had longstanding behavioural problems which potentially made it less likely that training on its own would produce substantial behavioural change. Further, they highlighted the inconsistency of approaches across services, professionals, and other important people involved in the children's lives, as potentially mitigating such change. They explained that a training programme will be less effective if such people use different approaches /strategies which undermine or contradict those that carers have been taught. To support carer training programmes, and maximise their potential, changes at a system level are important (Hill-Tout et al., 2003). For example, they recommended that teachers and social workers participate in training alongside foster carers so that they can provide the carers with appropriate ongoing support. They stated that training on its own is likely to have limited benefits, and that it needs to be part of a broader support package (Pithouse, Hill-Tout, & Lowe, 2002).

Nilsen (2007) noted that the lack of significant change in child behaviour in the studies by Macdonald and Turner (2005) and Hill-Tout et al. (2003) was likely due to the brevity of the interventions and insufficient time between sessions for carers to practice the skills. Moreover, they believed that the caregiving skills taught were not specific enough. In order to address a wide range of child developmental stages these training programmes

needed to include a broad range of caregiving skills. Nilsen (2007) therefore investigated the effects of a 12-week training programme. This is much longer than three-day and four-week training programmes described in the previous studies. The training also focussed specifically on foster carers looking after children aged 5-12. The programme was an augmented version of the Incredible Years parenting programme, an evidence-based intervention for birth parents based on the principles of SLT. Through the use of role-play, videos, group discussion, and homework tasks, it teaches parenting skills (e.g. non-violent discipline techniques, praise and attention) to help promote the development of children's prosocial skills and reduce their conduct problems (Nilsen, 2007). The Incredible Years manual was used but the group discussion content was modified and it included additional materials which were specific to the experiences of foster carers and needs of children in care. The authors did not provide details on what these were. In this U.S study, 18 carers were allocated (non-random) to the intervention group (n=11) or to the comparison group (n=7). Quantitative data was collected before and two weeks post training (Nilsen, 2007).

Quantitative results showed that carers in the intervention group reported significantly less conduct symptoms post-training than those in the comparison group (Nilsen, 2007). However, no statistically significant differences were found between the two groups at either time point in carer-related outcomes: stress in the caregiver-child relationship, parenting knowledge and understanding of child development. The authors hypothesised that this may have been because the quantitative measures were not sensitive enough to capture the changes that had occurred. In contrast to these findings, the intervention carers reported in a satisfaction questionnaire that their caregiving had improved, that they felt more competent, and were very satisfied with the programme. Further, qualitative comments indicated that the most valuable aspect of the programme was being able to share their experiences with other carers. While this study did find some changes in child behaviour, the methodological limitations of the study, including the small sample size and lack of a randomised control group, makes it difficult to draw conclusions regarding its effectiveness (Nilsen, 2007).

Training programmes which are based on, or incorporate, Attachment Theory.

It has been argued that carer training programmes primarily based on SLT principles, which have been developed from parent training programmes (i.e. birth parents), do not meet the specific needs of this complex population. It is believed that these programmes need to emphasise the trauma and attachment-related difficulties of children in care. Therefore, it is important that the curriculum also includes Attachment Theory and emphasises the impact of

childhood trauma on child development (Allen & Vostanis, 2005; Golding, 2007; Sinclair, 2005b).

Allen and Vostanis (2005) conducted a non-randomised controlled study with 17 foster carers from local authorities in England, who participated in an Attachment-based training programme of seven weekly 2 ½ hour sessions. The programme aimed to go beyond behavioural management strategies and increase carers' understanding of children's different attachment patterns and the impacts of trauma and neglect on child development. The foster carers' social workers were invited to participate in the training so that they could provide carers with ongoing support post-training in implementing the skills and knowledge taught, something which was recommended by Hill-Tout et al. (2003). Focus group discussions following training were used to evaluate the impacts of the programme. Measures of child outcomes were not included (Allen & Vostanis, 2005). Participants spoke very positively about the programme. The discussions revealed that carers felt more confident in their caregiving abilities, and had more realistic expectations of their child. This led to reduced self-blame for their child's level of functioning. Carers also discussed how they had a greater understanding of their child's difficulties which subsequently helped to reduce the negative emotional impact these had on them. Several carers also discussed how this increased understanding helped them to persist during challenging times when before they would have considered ending the placement. The carers however, expressed a desire for regular follow-up sessions to support them when experiencing difficulty in applying the strategies that were taught, and to ensure that changes to their caregiving approach were sustained over time (Allen & Vostanis, 2005).

Minnis et al. (2001) conducted an RCT to evaluate the effects of a foster carer training programme on foster children's emotional and behavioural functioning. 121 foster carers from Scotland were randomly allocated to the training or control group (standard services). The programme ran for 3 days, with training sessions of 6-hours per day. The programme included training on communication skills and attachment, and was based on an established programme designed for birth parents. Little detail was provided on the specific content of this programme and it is not known to what extent Attachment Theory was incorporated. Quantitative data was collected before, directly after training, and at a 9-month follow-up. Carers' scores on a training evaluation questionnaire indicated that they perceived the training as beneficial. They perceived improvements in their caregiving skills, child's behaviour, and in their relationship with their child. Despite this, no statistically significant differences were found directly following training or at follow-up in regards to children's

level of psychopathology and attachment. However, the authors noted that while these effects were not statistically significant they were potentially clinically significant. Minnis et al. (2001) concluded that this training programme was not sufficient to make a substantial improvement in the children's psychopathology and that a more intensive intervention is required.

Holmes and Silver (2010) conducted a non-controlled pre-post evaluation of a group training programme which incorporated both SLT and Attachment Theory. The programme emphasised the importance of empathy and attunement in improving the child-carer relationship and reducing child behaviour problems. A sample of 44 foster carers and adoptive parents participated in the training which consisted of six weekly sessions (the length of these sessions was not provided). Data were collected before and after training. Results showed a statistically significant increase in participants' scores for the child-adult relationship indicating that it was perceived as more positive following training. Further there was a statistically significant decrease (improvement) in scores relating to participants' perceptions of their child's problem behaviours. However, given that there was no control group, these findings must be interpreted with caution. Participants rated the content, relevance and impact of the group highly (i.e. were very satisfied with the programme). Further, they rated that they felt more confident in themselves as a carer. Qualitative feedback revealed that all participants believed that their caregiving had improved following training, and would recommend the programme to others. Majority mentioned how they had an improved understanding of their child's behaviour, and that this, along with the use of specific techniques taught, meant they had a calmer approach to challenging situations. Commonly mentioned by participants were the benefits of carers being able to share experiences within the group, which helped them to realise that they were all facing similar issues. Some carers suggested that a follow-up session six months post training would be helpful (Holmes & Silver, 2010).

Summary. The findings from these 'one-off' studies indicate that carers' are satisfied with the training they received. Further, carers report increased levels of confidence in their caregiving abilities following training. These are valuable outcomes of training as they can be important in helping to maintain placements and therefore provide the stability that these children need (Golding, 2006a). However, findings from majority of the studies revealed a lack of significant measurable change in child behaviour problems. A lack of change in children's behavioural difficulties does not necessarily mean that the training is not successful (Golding, 2006a). Developmental recovery for these children is very slow and

occurs over several years. More critical than a reduction in children's problems, is the carer's ability to cope, provide sensitive care, and commit to their child (Nilsen, 2007; Pithouse et al., 2002; Tarren-Sweeney, 2014). Long-term, permanent placements are key to the child's developmental recovery (Tarren-Sweeney, 2014). However, the prediction that those who participated in training would experience fewer unplanned placement breakdowns was not supported by the two studies which measured this outcome (Herbert & Wookey, 2007; Macdonald & Turner, 2005). Further, the two studies which assessed carers' levels of stress did not find any statistically significant changes following training (Hill-Tout et al., 2003; Nilsen, 2007).

In regards to improvements in caregiving abilities, results across these studies are mixed. This may be due to the different ways in which they were assessed. The studies by Herbert and Wookey (2007) and Macdonald and Turner (2005) found that training had a significant impact on carers' knowledge of behavioural principles. In contrast to this, Hill-Tout et al. (2003) did not find that their training programme had measurable effects on carer capacity, including their responses to, and understanding of, challenging child behaviour. This is despite carers expressing strong approval of the training and that it had been helpful. Similarly, despite carers reporting that their caregiving had improved, Nilsen (2007) did not find any measurable impacts of training on caregiving attitudes and knowledge, including their understanding of child development. Qualitative data from the studies by Allen and Vostanis (2005) and Holmes and Silver (2010) revealed that carers' had perceived improvements in their caregiving following training, including a greater understanding of their child and their behaviour, and improved empathy.

The Fostering Attachments training programme

Four studies have evaluated the Fostering Attachments training programme (Golding & Picken, 2004; Gurney-Smith, Granger, Randle, & Fletcher, 2010; Laybourne et al., 2008; Wassall, 2011). The programme is based on both Attachment Theory, and principles of Social Learning Theory (SLT). It provides carers with psycho-education on Attachment Theory, and then through the use of role-play, group discussion and exercise, teaches carers how to practically apply this theory to their caregiving (Golding & Picken, 2004; Laybourne et al., 2008). The attachment-based parenting model by Hughes (1997) is emphasised. This model recommends that carers build a secure base for their foster child by creating a positive family atmosphere in which the child feels a sense of belonging. Security and trust within the

child-carer relationship forms the necessary foundation from which appropriate rewards and punishment can then be applied to manage the child's challenging behaviour (Golding, 2006a). The programme aims to increase carers' understanding of their child, caregiving skills and confidence, (Golding & Picken, 2004; Wassall, 2011).

The studies by Golding and Picken (2004), Laybourne et al. (2008) and Gurney-Smith et al. (2010) were all conducted with participants from England and utilised a pre-post study design to evaluate changes in both carer- and child-related outcomes. None of these studies had a control group, and only one included a follow-up assessment which was three months following training (Gurney-Smith et al., 2010). Golding and Picken (2004) and Laybourne et al. (2008) evaluated the programme with foster carers only, with small sample sizes of six and seven carers respectively. The study by Gurney-Smith et al. (2010) included a sample of 13 foster carers and adoptive parents. All studies administered carer-rated quantitative measures. Golding and Picken (2004) and Laybourne et al. (2008) also included qualitative data obtained post-training from group discussions and semi-structured interviews, respectively.

There was variability in the findings across the three studies. Two of the studies found statistically significant improvements in carers' reports of their child's emotional and behavioural functioning (Golding & Picken, 2004; Gurney-Smith et al., 2010), whereas the other study did not (Laybourne et al., 2008). In the study by Gurney-Smith et al. (2010) these improvements were only found at the 3-month follow-up and not directly post training. Two of the studies did not find any statistically significant changes in children's attachment-related child behaviours (Golding & Picken, 2004; Laybourne et al., 2008). Golding and Picken (2004) noted that carers' scores remained relatively high post intervention indicating the continued presence of their child's attachment difficulties. While Gurney-Smith et al. (2010) found a statistically significant improvement in carers' perceptions of their child's disinhibition this was not the case for the child's inhibition and emotional dysregulation.

Of the two studies which evaluated carers' stress, only one found statistically significant decreases in carers' overall level of stress associated with caregiving (Laybourne et al., 2008). Golding and Picken (2004) and Gurney-Smith et al. (2010) reported statistically significant improvements in carers' perceptions of their caregiving skills and ability to understand the child well. For the latter study these findings were sustained at the 3-month follow-up (Golding & Picken, 2004; Gurney-Smith et al., 2010). Although these significant measurable improvements were not found by Laybourne et al. (2008), qualitative data revealed that carers had an increased understanding of their child's difficulties and therefore

how to respond more appropriately to their child's behaviour. Further, carers described how this increased understanding helped to sustain the placement (Laybourne et al., 2008)

Despite the variability in the above findings, the training programme was rated highly by carers across all three studies. Further, in all three studies carers reported the benefits of the group format, which included being able to share their experiences with other carers, hearing similarities in the challenges experienced, and feeling supported (Golding & Picken, 2004; Gurney-Smith et al., 2010; Laybourne et al., 2008).

While these three studies did find some positive outcomes supportive of the programme, the inconsistency in findings across these studies as well as their methodological limitations makes it difficult to draw conclusions regarding its effectiveness as a programme. Wassall (2011) aimed to improve on these earlier evaluations by conducting a study which included a larger sample, a control group, and a longer follow-up period to assess the maintenance of effects over time.

Wassall (2011) conducted a non-randomised controlled trial with a sample of 25 foster carers and adoptive parents from England, who were assigned to either the 'Fostering Attachments' group or a waitlist control group (underwent the programme at a later time). Quantitative measures were administered for both groups before and directly after the programme, and at an 8-month follow-up for the first group that underwent training. Despite having a larger sample size than previous evaluations, the sample size did not provide sufficient statistical power to detect meaningful differences between the two groups and therefore the authors decided to combine the data from both groups to analyse pre-post changes. No significant changes in outcomes were found over the waiting-list period which meant that the authors could more confidently assume that any changes following training could be attributed to the effects of programme itself rather than other variables such as time (Wassall, 2011).

Results showed that the only outcome variable to change significantly from pre to post intervention was carers' sense of competence and confidence in their caregiving skills. This finding was maintained at follow-up. Carers' self-efficacy significantly improved at follow-up but not directly post-training. No statistically significant changes were found post-training or at follow-up for carers' stress levels or Mind-Mindedness (carer's perceptions of their child's thoughts and feelings), children's emotional and behavioural functioning, or children's sense of security (Wassall, 2011).

Several limitations of this study should be considered when evaluating its findings. While the sample size in this study was larger than in previous evaluations, it was still too

small to provide sufficient power which increases the probability that significant differences are not detected. Another limitation is the reliance on carer-report measures. This increases the risk of bias (Wassall, 2011). The use of other informants and different types of measures (e.g. objective measures), may mean that change is more likely to be captured.

The authors concluded that improvements in carers' sense of competence and confidence in their caregiving ability, and self-efficacy is a valuable finding as it may lead to further positive impacts on carers' wellbeing (Wassall, 2011). Research suggests that higher levels of self-efficacy can reduce the negative impacts of challenging child behaviour on carers' stress, anxiety and depression (Morgan & Baron, 2011). However, this study did not find any significant changes in carers' stress. The author suggested that this may be due to carers' very high stress levels measured at baseline which is not unexpected given their very challenging role. This potentially indicates that carers require more support than is provided by a single training programme such as Fostering Attachments (Wassall, 2011).

Despite improvements in this carer-related outcome, the study did not find significant measurable changes in children's difficulties (Wassall, 2011). This is congruent with the findings from other studies of foster carer training programmes (Herbert & Wookey, 2007; Hill-Tout et al., 2003; Macdonald & Turner, 2005; Minnis et al., 2001). Wassall (2011) suggested that given the severity and complexity of these children's difficulties, it is perhaps unrealistic to expect changes within an eight month period post-training, and that future evaluations should include a longer follow-up period. Given the lack of positive changes in most outcomes variables assessed, the study concluded that the Fostering Attachments programme is not enough to address the challenges that carers experience and perhaps might be more beneficial as part of a multi-component intervention (Wassall, 2011).

KEEP training programme

KEEP (Keeping Foster and Kinship Parents Trained and Supported), an 'in-service' training programme for foster and kinship carers, is a version of Multidimensional Treatment Foster Care (MTFC) intervention (Price, Roesch, & Walsh, 2012). MTFC is an intensive treatment intervention based on the principles of Social Learning Theory (SLT) which involves the placing of youth, who have severe emotional and behavioural problems, within a well-trained foster family. These foster carers receive support and training to help reduce the problem behaviours of these young people and improve their pro-social skills (Chamberlain, 2003). Whereas MTFC is designed for specially trained foster carers who care for one child

over a certain period, KEEP targets foster carers who already have a child in their care i.e. existing foster placements (Tarren-Sweeney, 2014).

The overall objective of KEEP is to provide carers with the skills to help them deal with and reduce their child's behavioural and emotional difficulties, and to prevent placement breakdown (Chamberlain, Price, Reid, & Landsverk, 2008). The programme focusses on increasing carers' use of positive reinforcement, effective limit setting, non-harsh discipline strategies, and strategies to help carers' manage their stress (Chamberlain, Price, Reid, et al., 2008; Price, Chamberlain, Landsverk, & Reid, 2009). The carer focuses on applying the strategies to one particular child in their home (Price, Roesch, Walsh, & Landsverk, 2015). The content is delivered in a group format and utilises group discussions, role plays, and videos (Price et al., 2009).

A large RCT was conducted to evaluate the effectiveness of the KEEP intervention. A sample of 700 foster/non-relative (66%) and kinship/relative (34%) in San Diego County, California, with a foster child between 5 to 12 years of age, were randomly allocated to the KEEP programme or to a control condition (standard casework services which included some form of other training). Carers in the KEEP intervention participated in 16 weekly, 90-minute training sessions. Training groups consisted of approximately 3-10 carers, each run by two training facilitators. Facilitators also phoned the carers weekly to provide additional support (Chamberlain, Price, Leve, et al., 2008; Price et al., 2008)

Several analyses have been conducted using the same RCT but which evaluate different outcome variables. Chamberlain, Price, Leve, et al. (2008) found that child behaviour problems reduced significantly more in the intervention (KEEP) versus the control group. In the intervention group, the mean number of behaviour problems per day reduced from 5.9 (pre) to 4.4 (post), whereas in the comparison condition it reduced from 5.8 to 5.4. The carers' increased use of positive reinforcement partially mediated this reduction. This mediation effect was greater for those children who had more behavioural problems at baseline and were categorised by the study as high risk (Chamberlain, Price, Leve, et al., 2008).

Using the same RCT, Price et al. (2008) investigated the effects of KEEP on placement stability. Results showed that children of carers in the KEEP intervention were almost two times more likely than those in the in the control group to experience a positive exit from their placement (i.e. reunification with birth parents or shift to a permanent placement). However, no difference was found between the groups for negative exists (i.e. unplanned placement breakdowns). Despite the latter finding, results showed that a greater

number of prior placements increased a child's risk of experiencing future placement breakdown, but that being in the intervention group mitigated this risk-enhancing effect (Price et al., 2008).

Price et al. (2015) investigated the effectiveness of the KEEP intervention when delivered by a community agency in San Diego, California, independent of the research centre intervention team. The aim was to examine whether the intervention would lead to reductions in the behavioural difficulties of more than one child in the home, as well as reduce carers' stress levels. Further, it aimed to investigate if the effects of KEEP, as demonstrated in the large RCT trial, could be maintained within a real-world clinical setting. A sample of 335 foster and kinship carers were randomly assigned to the KEEP intervention (n=164) or control condition (n=171). Quantitative data was collected before and after two weeks following training (Price et al., 2015).

Results showed a significantly larger pre-post reduction in scores of child behavioural difficulties, in the intervention group compared to the control group. This was the case for both the target child (carers' primary focus during training) and the sibling child (other child in the home) (Price et al., 2015). One proposed mechanism for this generalisation effect was that carers were able to transfer the skills learnt regarding the target child, to other children in their home. Another potential mechanism was that carers' successful experiences in managing the target child's behaviour provided them with more confidence and time to then focus on the behavioural problems of other children in the home. The results also showed a significant pre-post reduction in carers' stress associated with the target child's behavioural difficulties, for the intervention group but not the control group (Price et al., 2015).

An important limitation found in these studies of KEEP, is that participants were not blind to group allocation. This may have led to a response bias. Carers' knowledge of what group they were in could have influenced their perceptions of change in themselves and their child. This is particularly problematic given that these studies only utilised carer ratings of outcome variables. No other informants (e.g. teacher, social worker) were used.

The California Evidence-based Clearinghouse for Child Welfare, an organisation which evaluates the effectiveness of mental health interventions for children and families in the child welfare system, gave KEEP a rating of three: 'Promising Research Evidence'. This is based on a five point scientific rating scale where one indicates that the intervention is 'Well Supported by research evidence', and five indicates 'Concerning Practice' (The California Evidence-Based Clearinghouse for Child Welfare, 2013). An important unanswered question from these evaluations is whether or not the effects of KEEP are

enduring post-training. KEEP did not receive a higher rating from Clearinghouse because the RCT trial did not conduct a long-term follow-up. The intervention must show sustained effects of at least six-months post-training in comparison to a control group (The California Evidence-Based Clearinghouse for Child Welfare, 2013).

The Fostering Changes training programme

The Fostering Changes programme was first established in 1999 in London Southwark by the Adoption and Fostering National Team at the Children's Department of the Maudsley Hospital (Bachmann et al., 2011; Briskman et al., 2012; Warman, Pallett, & Scott, 2006). The rationale for developing this programme was based on the need expressed by foster carers themselves, for better skills and strategies to help manage challenging child behaviour (Bachmann et al., 2011). Local social and health services at the time expressed concern for the scarcity of such support. In response to this, funding was granted in 1998 for the development of a service which provided support and skill development for foster carers (Pallett, Scott, Blackeby, Yule, & Weissman, 2002).

Characteristics of the programme. The Fostering Changes training programme was designed to promote positive carer-child relationships and develop carers' skills in managing difficult child behaviours. The key theoretical underpinnings are Social Learning Theory (SLT) and Cognitive Behavioural Theory (CBT), and in the most recent addition a greater emphasis on Attachment Theory (Bachmann et al., 2011; Pallett et al., 2002; Warman et al., 2006). The following description of Fostering Changes is on the key components of the programme which appear to have remained relatively the same over time and across the different manual editions.

A positive carer-child relationship is recognised as providing a necessary foundation from which positive change can then be brought about (Pallett et al., 2002; Warman et al., 2006). To help develop a more positive relationship, carers are taught how to focus more on the child's appropriate behaviours, giving suitable praise and reward, and providing positive attention when appropriate (Pallett et al., 2002). Carers are also encouraged to reflect on their own behaviours including how they interpret and respond to the child's needs and behaviour, and ways in which they communicate with the child. As a result carers are able to provide new experiences for the child, which can improve how the child perceives themselves and others (Warman et al., 2006).

Strategies derived from behaviourally-based parenting programmes have been incorporated into Fostering Changes. Carers are taught how to observe and clearly describe their child's behaviour so that they are able to track when and where it occurs. Understanding the context in which behaviour occurs including the role of antecedents and consequences, is a necessary step for bringing about behavioural change. Carers are taught how to set limits, give clear instructions, and deal with conflict and oppositional behaviour safely and effectively (e.g. using time-out and selective ignoring) (Bachmann et al., 2011; Pallett et al., 2002; Warman et al., 2006).

Fostering Changes uses a group format. This allows carers to share their experiences with others and to receive advice from both the programme facilitators and other carers. Further, they have the opportunity to vent their frustrations and concerns to people in a similar position to themselves. Listening to other carers who may be struggling with similar issues can provide a sense of relief and empowerment (Pallett et al., 2002). A collaborative approach to training is used, in which carers are actively involved and work together with the facilitators in finding potential solutions. This approach has been derived from the parent training model established by Webster-Stratton. Both the carers and facilitators are regarded as 'experts' in their own right who have valuable knowledge and experience which they contribute to the group. In addition to the theoretical material there is a strong emphasis on the practical component during which the carers try out the ideas and skills taught through group discussions, role plays and home practice (Bachmann et al., 2011; Pallett et al., 2002; Warman et al., 2006).

How the programme has changed over time. The first addition of the Fostering Changes manual was published in 2005 and the second edition in 2011, both by the British Association for Adoption and Fostering (BAAF), (Bachmann et al., 2011). The development of the second edition was largely driven by the significant advancement in knowledge regarding the impact of abuse and neglect on children, over the last 5 years since the first edition of the programme had been established. The authors claim that the second edition includes more on Attachment Theory and emphasis on providing carers with the necessary skills and support for improving the educational outcomes of looked-after-children. It also provides 12 rather than 10 sessions (Bachmann et al., 2011; Briskman et al., 2012). See Appendix A for a brief description of each of the 12 sessions.

As described by the authors, in the second edition of the manual carers are educated on the negative effects a history of abuse and neglect can have on a child's attachment security and emotional regulation, and how this in turn can impact the child's behaviour and

how they interact with others (Bachmann et al., 2011). There is greater emphasis on providing carers with the techniques to help their child recognise and manage their emotions more effectively, which as a result improves their behaviour and the child-carer relationship. In addition to this, carers are taught how to better regulate their own thoughts, feelings and behaviours so that they can respond in a more sensitive and appropriate manner that is congruent with the child's needs (Bachmann et al., 2011).

Lower educational attainment is recognised as a risk factor for subsequent disadvantage in many aspects of life (Briskman et al., 2012). The second edition responded to the White Paper, *Care Matters: Time for change* (Department for Education and Skills, 2007), which highlighted the importance of education in improving life outcomes for looked-after-children. As described by the authors, this edition teaches carers how to engage with the educational system so that they can gain access to the appropriate services to maximise their child's potential (Briskman et al., 2012). Further, they are provided with skills which help them to become more involved in their child's school-life (Bachmann et al., 2011).

The skills and theory taught in the Fostering Changes programme applies to both non-relative foster carers and kinship carers. The programme has not been specifically designed for one or the other, but in fact is aimed at a range of different carers: kinship and non-relative carers, long-term and short term carers, and pre-adoptive placements (Bachmann et al., 2011).

Empirical evidence of Fostering Changes. There have been three evaluations conducted on the Fostering Changes programme. A description of each study and the results that were found are discussed in the following section.

First evaluation. A non-controlled study using a pre-post design was conducted with 60 foster carers in Southwark London (Pallett et al., 2002). At this stage a training manual for Fostering Changes had not yet been developed. The training programme was based on the Incredible Years parent-training programme and was therefore underpinned by both CBT and SLT (Allen & Vostanis, 2005; Golding & Picken, 2004; Kinsey & Schlösser, 2013). The training consisted of 10 weekly, 3-hour sessions, and was delivered to groups of approximately 6-12 carers. Separate training was provided for carers of teens from those carers of children younger than 12. The training programme was adjusted for each group in order to be age-appropriate (Pallett et al., 2002). Data were collected approximately one month before and one month after the trial (personal communication with author Stephen Scott). This meant that there were approximately four months between data collection points.

Several carer-rated quantitative measures were administered. From the Parenting Stress Index (PSI), both the Carer-Child Dysfunctional Interaction Scale and the Difficult Child scale were used. The Carer-Child Dysfunctional Interaction Scale “focusses on the parent’s perception that his or her child does not meet the parent’s expectations, and the interactions with his or her child are not reinforcing to him or her as a parent” (Abidin, 1995, p.56). The Difficult Child scale includes the behavioural characteristics of the child (Abidin, 1995, p.56). The Strengths and Difficulties Questionnaire (SDQ), a behavioural screening questionnaire, was also used. The Carers Defined Problems Scale (Scott, Spender, Doolan, Jacobs, & Aspland, 2001) was also administered in which carers identify three specific concerns of their child and rate the severity on a 10 point scale from ‘no problem’ to ‘could not be worse’. A consumer satisfaction questionnaire was completed by the carers at the end of training from which both quantitative and qualitative data were drawn (Pallett et al., 2002).

Of the 60 carers who completed training only 10 carers completed the Carer-Child Dysfunctional Interaction Scale and the Difficult Child scale. For both measures results showed a statistically significant pre-post decrease with an effect size of 0.28 (small), and 0.93 (large) respectively. Data from the Carer Defined Problems Scale and the SDQ were obtained from 36 carers. For the former, results showed a statistically significant pre-post decrease in the severity of carers’ specific concerns of their child, with a large effect size of 1.4. On the other hand, results obtained from the SDQ were mixed. No statistically significant difference was found for hyperactivity and conduct problems, although a statistically significant decrease on the emotional problems scale was found (small effect size of 0.29). Results from the consumer satisfaction questionnaire showed that majority of the participants rated ‘definitely/a lot’ or ‘very/very much’, for feeling more confident in their ability to manage their child’s difficult behaviour (97%), that they would recommend it to a friend (97%), usefulness of subject matter (93%) and amount of behaviour change in the child (81%). Qualitative comments were also very positive (Pallett et al., 2002).

In summary, the authors concluded that the training programme improved child behaviour and emotions, and the quality of the carers’ interactions with the child, but that further research was needed to confirm these findings (Pallett et al., 2002). This is a very general statement and does not represent the variability of the findings. It is important to consider the improvements on the Carer-Child Dysfunctional Interactions scale which had only a small effect size, and the non-significant changes on specific SDQ subscales.

Second evaluation. Warman et al. (2006) conducted a non-controlled study using a pre-post design, with the first edition of the training manual. There were no changes to the

content or format of the programme from the first evaluation, only that it was now manualised (personal communication with author Stephen Scott). The sample consisted of carers who had taken part in the programme over the last six years. As in the first evaluation, data were collected one month before and after training. The quantitative measures were also the same except that results for the Carer Distress subscale and Total Stress of the PSI were also included. The Carer Distress subscale focusses on the distress the carer is experiencing which is directly related to caregiving. Qualitative data were provided by carers' responses to open-ended questions on a consumer satisfaction questionnaire. The sample sizes which contributed to the evaluation varied between 39 and 95 (Warman et al., 2006).

Results were combined for carers of teens and under-12s (Warman et al., 2006). A statistically significant decrease was evident for the Difficult Child scale, however in contrast to the first evaluation which found a large effect size, in this study only a small effect size of 0.33 was found. Statistically significant decreases were evident for the Carer Distress scale and 'Total carer stress', with small effect sizes of 0.21 and 0.27 respectively. In contrast to results from the previous evaluation, the pre-post change in scores for the Carer-Child Dysfunctional Interaction Scale was non-significant. Consistent with previous findings, the most notable improvements were found for the Carer Defined Problems Scale. Improvements (declines in severity of behaviour) were statistically significant with large effect sizes ranging from 1.23-1.37. Also consistent with previous findings, pre-post changes on the subscales of the SDQ were non-significant, except for the emotional problems subscale and the 'total difficulties' score but which had small effect sizes of 0.17 and 0.21 respectively. The authors suggested that this result may be due to the properties of the SDQ measure; it is more of a screening tool and is not as sensitive to change. Feedback and comments on the satisfaction questionnaire indicated that in addition to the specific content of the training, the approach to training was also important. Carers valued the group format and learning from other carers' experiences. Further, they were satisfied with training and reported increases in their confidence (Warman et al., 2006).

When taking into consideration both the statistical significance of the change in scores and the effect sizes, the two evaluations provided mixed results for the Difficult Child scale and the Carer-Child Dysfunctional Interaction Scale of the PSI. Moreover, improvements on the SDQ were found for only some of the subscales and these had small effect sizes. The most notable changes in scores consistent across both evaluations were for the Carer Defined Problems Scale. Further, carers' level of confidence and self-efficacy improved, and overall they were very satisfied with the training (Pallett et al., 2002; Warman et al., 2006).

Third evaluation: Randomised Controlled Trial (RCT). While the results from these first two evaluations are promising for both child and carer-related outcomes, they must be interpreted with caution given the lack of a control group. The authors acknowledged the importance of conducting a controlled trial to confirm that the results were in fact due to the training itself and not some other unknown variable (Pallett et al., 2002; Warman et al., 2006). The results could potentially be attributed to the passage of time, or other potential biases. Further research was needed to eliminate the possibility that the positive outcomes found were largely the result of the child becoming better adjusted to their foster carer with time and/or improvement in carer behaviour over time. A Randomised Controlled Trial (RCT) was therefore conducted to provide stronger empirical evidence for the benefits of the programme for foster carers and their children, which in turn would aid in justifying funding for the provision of more training courses run by local authorities (Briskman et al., 2012).

The RCT used the second edition of the Fostering Changes programme which had been published in 2011 by BAAF (Briskman et al., 2012). The training was delivered to groups of approximately 10 carers, and consisted of 12 weekly, 3-hour sessions. Participants were foster carers, male and female of any age, caring for at least one child aged between 2-12 years of age. They were recruited from four local authorities in and around London which were currently unable to run their own training courses. A sample of 63 participants were randomly assigned to the intervention (n=34), or waitlist control group (n=29; participated in the programme after post-trial data were collected). All participants completed carer-rated quantitative measures before and directly after training. Some of these measures were completed for both the 'target' child (focus of the training) and other foster children in the home. The intervention carers also completed a satisfaction questionnaire post-training (Briskman et al., 2012).

Carers rated the severity of their target child's most challenging behaviours using the Carer Defined problems scale (Briskman et al., 2012). There was a greater pre-to-post decrease in carers' severity ratings for the intervention group compared to the control group. This was statistically significant with a large effect size of 0.99. When the analysis was completed for all children (target child, and other children in the home), similar results were found, which suggested that the effects of training generalised to other children being cared for (Briskman et al., 2012).

The intervention group showed a greater pre-to-post improvement compared to the control group in the mean score for Total Problems (effect size of 0.32), and for the Hyperactivity subscale (effect size of 0.37) of the SDQ (Briskman et al., 2012). These group

differences were statistically significant. When the analysis was conducted with all children, similar results were found for Total Problems. Further, in comparison to the control group the intervention group showed a greater pre-to-post improvement in scores on the Conduct Problems Scale which was statistically significant. Again, these results suggested that the effects of the training had generalised (Briskman et al., 2012).

The QUARQ (Quality of Attachment Relationships Questionnaire) was administered to evaluate the attachment relationship between carer and ‘target’ child. Results showed a greater pre-post improvement in the mean score for the intervention group compared to the control group. This group difference was statistically significant with an effect size of 0.4 (Briskman et al., 2012).

A Carer Efficacy questionnaire was administered to evaluate carers’ belief in their ability to understand and manage their child’s behaviour, and to make a positive change in their foster child’s life (Briskman et al., 2012). There was a greater pre-to-post change in the mean score for the intervention group compared to the control group. This group difference was statistically significant with a large effect size of 0.7. In fact, while the mean score increased (improved) for the intervention group, it decreased for the control group. For three additional items related to quality of life, no statistically significant changes were found for either group. The Carer’s Coping Strategies questionnaire was administered to evaluate the extent to which carers applied the strategies taught in the training. There was a greater pre-to-post change in scores for the intervention group compared to the control group. This was statistically significant with a moderate effect size of 0.5 (Briskman et al., 2012).

Feedback from the satisfaction questionnaire was consistent with the above findings. All carers who completed the questionnaire (n=31) perceived at least some positive change in the behaviour of the ‘target’ foster child (Briskman et al., 2012). This was also the case for other children being cared for. Further, all carers who rated their relationship with their child (n=21), reported that it had improved substantially. When asked how the training impacted on them as a carer, all responses provided were positive. Fifty percent reported that it had increased their confidence, and 29% said they had increased self-esteem (Briskman et al., 2012).

In summary, results from the RCT provide evidence that participation in the Fostering Changes programme can lead to improvements in caregiving skills and carers’ confidence in their caregiving ability; reductions in child behaviour problems; and improvements in the child’s attachment security and in the child-carer relationship (Briskman et al., 2012).

Critical analysis of the RCT. From these three evaluations, in particular the RCT, it can be concluded that Fostering Changes shows considerable promise as a training programme for foster carers. An RCT is considered to be the ‘Gold Standard’ of evidence. Nevertheless, the methodology of this RCT did not control for some potential biases. Participants in the study were not blinded which may have resulted in a response bias. When completing the measures post-intervention, participants who had received the training programme may have either intentionally or unintentionally given what they perceived as a more favourable response. That is, they may have overestimated improvements in their own and their foster child’s behaviour. Participants may have responded in such a way out of fear that if there was little or no changes they would have somehow ‘failed’ the training course, and/or not been valuable to the research project. This potential response bias also holds true for the control group who had not received the training course and who as a result may have been more inclined to report changes in their own and foster child’s behaviour as being more minimal, worse, or non-existent.

Using a waitlist control group instead of an ‘alternative intervention’ or some kind of ‘placebo’ is another source of potential bias. As a result of using a waitlist control it is not possible to conclude with certainty that the positive results obtained can be attributed to the specific components of the training programme itself. They could instead be attributed to the qualities of the group facilitators or simply the availability of some form of support. The mere presence of other foster carers who share with the group their experiences as well as their empathy and encouragement, may be of greater importance than the theoretical and skill components of the training programme itself. Further, the personal qualities of the facilitators and the support they provide may give carers the inner strength needed to bring about positive change, independent of the training components.

Limitations and gaps within the literature

There does not appear to be any studies which have compared the outcomes of training programmes with different theoretical underpinnings (e.g. SLT, CBT, Attachment Theory). That is, the comparative effectiveness of these different training programmes is not known (Oke, 2010). More research is needed to understand which particular aspects of training programmes are most effective in producing change in carer- and child-related outcomes and which aspects are potentially unhelpful or least effective. This would help to inform the future development of these programmes (Rork & McNeil, 2011). Further, more

research is needed to understand the mechanisms of change. It is not clear *how* these training programmes produce changes in the carer and child (Golding, 2006a; Tarren-Sweeney, 2014). If more is known about these mechanisms then training programmes can be tailored to be more effective.

Majority of the studies within the literature evaluate training programmes by comparing group mean scores pre and post training and calculating the statistical significance of changes in these scores. This however does not capture variability in treatment responses and is not clinically meaningful. It would be more useful to know the proportion of children and/or carers who show improvement, those who do not change, and those who deteriorate. This provides greater insight into which variables (e.g. characteristics of the child and/or carer) predict positive change (Tarren-Sweeney, 2014). Further, there are very few qualitative investigations in the literature on the impacts of carer training programmes.

Evaluations of training programmes have relied on quantitative carer-report measures. Multiple informants (e.g. child's teacher, other family members) are rarely used. Further, observational measures of the child's and carer's behaviour are not administered. Using a multi-method and multi-informant assessment is important to help validate carers' reports of themselves and their child (Rork & McNeil, 2011).

Studies within the literature have focussed on assessing reductions in children's problem behaviours. The issue with this is that foster children's therapeutic recovery is very slow (Tarren-Sweeney, 2014). As previously discussed, this is a likely explanation for why a lot the studies outlined in this literature review did not find significant pre-post decreases in these problem behaviours. The quantitative measures typically used to assess these reductions are unable to identify small, early signs of developmental recovery. Moreover, they do not take into account the increases in pro-social behaviours that may occur infrequently but which may be considered as very meaningful to the carer (Tarren-Sweeney, 2014).

Another limitation within the literature is that it is not known to what extent different variables (e.g. characteristics of the carer, child and placement) optimise or hinder the effectiveness of these training programmes (Tarren-Sweeney, 2014). For example, it could be the case that the positive impacts of training on the child-carer relationship are limited for older children who have had a more unstable placement history. It appears that there have not been any studies which have investigated the extent to which there are differential effects of training on non-relative carers and kinship carers. Moreover, research is needed to discover *how much* training is needed (i.e. dose effects) to produce positive outcomes (Festinger & Baker, 2013; Rork & McNeil, 2011).

Little is known regarding the extent to which training programmes have an enduring impact on the carer and child. Numerous systematic reviews and studies on carer training programmes have recommended that future research should focus on the assessment of outcomes over longer follow-up periods (Briskman et al., 2012; Everson-Hock et al., 2012; Kerr & Cossar, 2014; Oke, 2010; Rork & McNeil, 2011; Turner et al., 2009; Wassall, 2011). Only a few studies within this literature review conducted follow-up assessments, all of which administered quantitative measures only (Gurney-Smith et al., 2010; Macdonald & Turner, 2005; Minnis et al., 2001; Wassall, 2011). The longest follow-up conducted was nine months (Minnis et al., 2001). This study only measured child psychopathology, and did not find any statistically significant changes. Moreover, this was a ‘one-off’ study of a training programme which has not been further evaluated. The long-term impacts of carer training programmes is an under researched area. It will be the focus of the rationale for the current study and is discussed in further detail below.

The rationale for the current qualitative study: exploring the perceived long-term effects of the Fostering Changes training programme

The complex symptomology of children in care tend to follow a long-term developmental trajectory. Foster placements which provide nurturing and consistent caregiving over several years are essential in facilitating the child’s developmental recovery (Tarren-Sweeney, 2014). Long-term evaluations are therefore important for discovering the extent to which training programmes are able to provide sustained improvements in carers’ psychological wellbeing, self-efficacy, caregiving skills and attitudes towards fostering, which help to ensure the long-term stability of placements. It may be the case that caregiving skills and strategies taught are forgotten and that as time from the training increases the caregiving environment deteriorates and positive changes flat-line or even reduce. There appears to be a lack of research investigating the level of ongoing support carers need following these single, time-limited training programmes.

As mentioned above, there are very few qualitative investigations in the literature on how training programmes impact on the child and carer. Moreover, the few studies which have conducted follow-up assessments have used quantitative measures only. Using a qualitative rather than quantitative method provides greater insight into the complexity of carers’ experiences regarding the impacts of training, *how* these vary over time, and *why*.

Qualitative studies produce more contextualised information therefore helping to shed light on processes of change.

The researcher was provided with the opportunity to conduct research with carers who had undergone the Fostering Changes programme. Additional to this opportunity, the evidence-base for Fostering Changes indicates that it is a very promising training programme leading to improvements in both carer- and child-related variables and for which further research is warranted. The three studies on the Fostering Changes programme outlined in this literature review are the only ones which have been conducted thus far, none of which contained a follow-up assessment (personal communication, Stephen Scott). For the first two evaluations there was approximately four months between data collection points and for the RCT approximately 3 months. In fact, the authors recommended that future research conduct a follow-up evaluation to investigate whether carers' continue to use their acquired skills and if positive changes in child behaviour are sustained (Briskman et al., 2012). Further, a comprehensive qualitative evaluation of the training programme has not been conducted.

Objective of the current study

The overall objective of the current study was to explore the perceived long-term effects of the Fostering Changes programme using a qualitative design. This involved investigating foster carer's perceptions and experiences in a 13-15 month period following their participation in the training programme. It is a small but very important starting point that will help to inform further research in this area. Evidence on the longer term impacts of training programmes such as Fostering Changes, could help to contribute to the development of an effective model of intervention for foster carers. Included within this model could be recommendations regarding the extent to which carers require long-term involvement in training, for example whether or not foster carers require booster/refresher sessions after a certain period of time post-training. This study will also help to inform any potential modifications that need to be made to Fostering Changes to increase its success as a training programme for carers.

Chapter Three: Methodology and Method

The first part of this chapter outlines the research question and research aims of this study. Following this, three potential qualitative methodologies are described. Interpretative Phenomenological Analysis (IPA) is explained in more detail for the reader as this became the chosen methodology for the study. Next, the study method is outlined. This includes a description of the study participants, procedure, data analysis, rigour and trustworthiness, and ethical considerations.

Research Question

How do foster carers perceive and experience the effects of participating in the Fostering Changes programme in the 13-15 month period following training?

Aims

This research had two aims. The first aim was to investigate what effects from Fostering Changes, if any, the participants experienced over the last 13-15 months, and how they perceived such effects or non-effects to have unfolded over this time period. Information was gathered on carers' recollections of any change in their fostering experience directly post-training and if, or how, this change had been sustained over time. The second aim was to explore carers' perceptions regarding any effects the programme had currently on their fostering experience. Carers were asked to reflect on whether, or the extent to which, the training was presently beneficial. Understanding was gained through rich descriptions of experiences and perceptions. For this reason a qualitative design was used in the present study. Further, due to the small sample size available, quantitative research was not feasible. It is hoped that the current study will not only add to the evidence base of Fostering Changes specifically, but will also be a valuable contribution to what is known about the long-term effects of these types of training programmes in general. It will provide a useful starting point for future research on this topic which in turn can help to inform policy development around training for foster carers.

Selecting the Qualitative Methodology

Qualitative research aims to explore, describe and interpret the experiences, thoughts, and feelings of individuals (Barker, Pistrang, & Elliott, 2002; Smith, 2008). Rather than reducing the data down to a simplified or quantifiable form, qualitative research aims to

provide rich and detailed descriptions (Barker et al., 2002; Bogdan & Biklen, 2007). The approach is typically inductive rather than deductive. This means that data are not collected for the purpose of testing hypotheses based on theory (i.e. deductive). Rather, concepts emerge from the data bottom-up (i.e. inductive), which can then be used to generate hypotheses (Bogdan & Biklen, 2007; Howitt, 2013). Given that the current study was concerned with capturing the diversity and uniqueness of individual experiences and perspectives, a qualitative rather than quantitative research method was chosen. There are however, numerous qualitative approaches to choose from. The following section describes some of these and the extent to which each fits with the aims of the current study. This was an important process for ensuring that the most appropriate and compatible methodology was selected. Three types of methodology appeared to be most relevant for the current study and were further investigated. These were Narrative Analysis, Grounded Theory, and Interpretative Phenomenological Analysis (IPA). There is no right or wrong methodology but instead one that is a more appropriate fit than another.

Narrative Analysis. Narrative Analysis is concerned with the narrative accounts (i.e. stories), of individuals' experiences (Howitt, 2013). This focus on individuals' experiences fits with the research aims. An interview can be conducted to obtain narrative data. The episodic interview appeared to be the most relevant for the current study as it focuses on particular periods or events, rather than the individual's entire life story (Howitt, 2013; Murray, 2008). The process of analysis involves exploration of the content, structure and function of the narrative. In addition to the identification of themes, the researcher also considers the tone of the narrative (e.g. manner and style of the narrative), how the narrative is organised, as well as its psychological and social functions for the individual (e.g. what the narrative reveals about how the individual constructs their identity), (Howitt, 2013; Willig, 2013). Moreover, the researcher is interested in the experiences expressed throughout the narrative, how these experiences are conveyed to the interviewer, and how the narrative is influenced by broader social and cultural contexts (Murray, 2008; Willig, 2013). This was beyond the purpose of the current study which focusses on the meanings of individuals' experiences, rather than *how* these are constructed and expressed through narrative. Another focus of narrative analysis is considering what the narrative reveals about the self and identity, which does not fit with the aims of this study (Howitt, 2013).

Grounded Theory. Grounded theory involves collecting and analysing data to develop a theory of the phenomenon of interest (Kathy, 2008; McLeod, 2003). The data are coded into units of meaning which are then integrated to form categories. With further

analysis, sub-categories and superordinate categories are then produced. These categories are grounded in the data and should not be influenced by existing theoretical concepts. In fact, researchers are encouraged to write their literature review after the data collection and analysis to help promote the discovery of new concepts and ideas that are not influenced by existing ones (McLeod, 2003). The emphasis on allowing categories to emerge from the data inductively, to ensure the theory or model is truly reflective of the study participants' actual experiences, was consistent with the aims of the current research.

Theory is developed through a continuous back and forth process between data collection and data analysis until theoretical saturation is reached. The process is cyclical. The researcher identifies and integrates categories and then collects further data until no new categories can be found. As new categories emerge the researcher may review and change earlier stages of the research (Willig, 2013). This makes Grounded Theory a very time-consuming and demanding process. Given the time constraints in completing this thesis, the use of Grounded Theory as the methodology of choice was problematic. While there is an abbreviated version in which only the original data set is used, it is advised that this should never be the researcher's first choice (Willig, 2013). It appears that this version lacks the true essence of Grounded Theory. Further, researchers using Grounded Theory generally aim to produce a theoretical claim based on the individual accounts of a larger study sample (Willig, 2013). According to McLeod (2003), Grounded Theory requires approximately 8 to 20 participants. Given the limited timeframe of this thesis, it would be difficult for the researcher to explore the experiences of a large number of participants in enough detail and depth. Most importantly, there is limited research exploring the long-term effects of a training programme for foster carers. Little is known in this area of research. Developing a theory around foster carers' experiences and perceptions of the long-term effects would therefore be premature. The aim of this research is to better understand participants' experiences, rather than to develop theory. As noted by Willig (2013), p.79 "research questions about the nature of experience are more suitably addressed using phenomenological research methods".

Interpretative Phenomenological Analysis (IPA). The aim of IPA is to explore in depth, how participants make sense of their life experiences, and the meaning that these experiences have for them. It is concerned with the participant's own unique perspective (Smith & Osborn, 2008). IPA recognises the active role of the researcher, who is involved in trying to make sense of, and *interpret*, the participants' descriptions of their experiences (Willig, 2013). There are three key theoretical underpinnings of IPA: *phenomenology*, *ideography*, and *hermeneutics* (Smith, Larkin, & Flowers, 2009).

From a phenomenological standpoint, it is not logical to conceptualise the world separately from our experiences of it. How the world appears to each of us depends on our location, context, thoughts, beliefs and expectations (Willig, 2013). An individual's experience of the world is therefore personal (Smith et al., 2009). IPA aims to richly describe an individual's unique experiences and perspectives of phenomena, rather than attempting to formulate some objective description of it (Smith et al., 2009; Willig, 2013)

IPA has an ideographic approach. This means that the researcher is focussed on investigating, in detail, the experience for *each* individual (Smith et al., 2009). This is different from a nomothetic approach which aims to study a representative group of individuals to then establish laws and/or generalisations (Howitt, 2013). The ideographic approach means that IPA studies often involve small sample sizes. Moreover, a semi-structured interview is a common data collection method that is used to ensure that rich data are obtained from the individual (Smith et al., 2009). It is important that questions are open-ended and non-directive to allow each participant to share detailed and personal descriptions of the phenomena of interest (Willig, 2013). In contrast to Grounded Theory, an IPA study focusses on producing a more in-depth analysis of the experiences of a smaller sample of participants (Smith 2009).

From an IPA approach, obtaining direct access to a participant's experience is not considered possible (Willig, 2013). The phenomenological analysis is an "interpretation of the participant's experience", which is influenced by the researcher's own beliefs and assumptions (Willig, 2013, p.87). Interpretative phenomenology is informed by hermeneutics, the theory of interpretation (Smith et al., 2009). IPA involves a double hermeneutic: interpretation by both the participant and the researcher. "The researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al., 2009, p.3). Description and interpretation are considered to be inseparable processes (Willig, 2013). Unlike IPA, Grounded Theory does not sufficiently acknowledge the active role of the researcher. Grounded theory aims to produce theories that emerge from the data with the researcher adopting a somewhat objective stance (McLeod, 2003).

In an IPA study, the process of interpretation involves a back and forth process between the parts and the whole of the participant's account. This is termed the hermeneutic circle (Smith et al., 2009). In order to make sense of the whole text the researcher needs to make sense of its individual parts (e.g. sentences), but to make sense of the parts you need to have an understanding of the whole (Smith et al., 2009). Another type of hermeneutic circle operates when the researcher is engaged in a back and forth process between their

presuppositions and interpretations as they try to make sense of the participant's account (Willig, 2013). The researcher's presuppositions influence their interpretation, but these presuppositions are continually revised as the researcher engages with the data. This however, does not mean that the research is biased (Willig, 2013). Informed by the work of Heidegger, a hermeneutic phenomenologist, IPA recognises that interpretation cannot be free of our presuppositions (Smith et al., 2009). "Inevitably, the analysis is a joint product of the participant and the analyst" (Smith et al., 2009, p.80). What is important is that the researcher acknowledges these presuppositions and tries to minimise their influence. The researcher attempts to 'bracket off' prior conceptions before each interview, as well as bracket themes that emerge from a participant's account when analysing the next one (Smith et al., 2009).

Given that the researcher plays an active role in the research process, they will be referred to in first person from this point onward.

The chosen methodology. In summary, this study required a methodology that focussed on exploring the experiences, thoughts and beliefs of individuals; allowed for a relatively small sample size; and provided clear guidelines for data collection and analysis. IPA appeared to be the most suitable methodology that was compatible with the aims of the study and which met the above requirements.

The study method

IPA was used in the current study to explore the perceived effects of the Fostering Changes programme during a 13-15-month period post training. IPA informed both the data collection procedure and data analysis.

Participants. The participants in this study were recruited from the cohort of carers who completed the Fostering Changes Programme through a community organisation in the Canterbury region. This organisation provides a range of social services and programmes to people of all ages in the community. They initially contacted Dr Michael Tarren-Sweeney requesting that research be carried out on the Fostering Changes programme, which is a training programme run by, but not limited to, their organisation. They agreed to provide access to their clients who participated in the programme. The organisation therefore facilitated this study. It should be made clear however, that they did not commission this study, nor was the study carried out on their behalf.

Given that the purpose of this research was to explore the perceived long-term effects of Fostering Changes, participants from one group who had completed the programme a

significant period of time ago, were targeted for inclusion in the study. This group consisted of step parents, kinship carers, and non-relative carers. A few of the non-relative carers were couples who completed training together. The step parents were not eligible to participate in this study. Step parents do not fit the population of interest, as, while, kinship care is now recognised as a form of foster care, step parenting is not. Step parents are not part of foster care services. According to the organisation, they allowed step parents to enter the programme on the basis that they were struggling to form a positive relationship with a child who was not biologically related. Although the programme catered for this relationship component, the other aspects related to understanding trauma and neglect were not particularly relevant to these parents. These children did not come from a child welfare and protection context. Both the non-relative carers and kinship carers were eligible to participate. As previously described, the Fostering Changes programme is aimed at both types of carers. It should be made clear that this study was not interested in making distinctions between the experiences and perceptions of non-relative foster carers and kinship carers. Interpretation and analysis was applied to the sample as a whole.

Each couple was asked to nominate only one carer to take part in the study. Moreover, one of the kinship carers did not agree to participate. In keeping with the requirements of IPA, a small group of seven participants was therefore targeted for the study: two kinship carers and five non-relative carers. After completing the interviews with all seven participants it was decided that two of the non-relative carers should be excluded from the analysis. Both of these carers were not experiencing any significant difficulty with caregiving that led them to seek out or be recommended the training. Rather, due to their high level of involvement with a local Foster Care Association, they were asked by Child, Youth and Family (New Zealand government agency for child protection) to take part in the training in order to assess and report back what they thought of it and the extent to which it would be helpful for foster carers to complete. Their situation was therefore very different to the other five participants who were experiencing difficulties within the family and/or wanted to improve their caregiving skills and knowledge. They had either chosen to undergo the training themselves or had been recommended it by their social worker.

Description of participant characteristics. To protect the anonymity of the participants a general summary of the participants is provided in lieu of more detailed individual participant profiles.

Four of the participants were females, of which three were middle-aged and one was in their early 60s. Two of the four were non-relative carers, and two were kinship carers. The

other participant was a male, middle-aged, non-relative carer. All carers were currently living with a husband/wife. Two of the carers were looking after another foster child in their home, of which one also had their own biological child living with them. The other three carers were currently only caring for one child (the 'target' child). Two carers had not had their own biological children.

The age of the 'target' child (focus of the training) ranged from 7-13 years old, and the number of years they had cared for this child ranged from 1½ -7 years. One carer was no longer caring for this child; they decided to end the placement approximately 10 months after completing Fostering Changes. They still provided care for the child occasionally in the weekends. Three of the five carers had attended some form of other caregiver training before Fostering Changes.

Procedure. Several meetings were held with the local organisation to discuss the research and how the Fostering Changes programme was run. The second edition of the programme manual was used, although a few adaptations were made by the facilitators. These are described in Appendix B. Once the details of the study had been finalised, a draft of the information sheet and consent form which would be sent to the carers, was given to the Social Services Manager of the organisation. This was done to inform the organisation on the details of the study for when they contacted the carers, and to allow them to advise any changes to the forms they believed necessary. They suggested two minor changes which were incorporated into the forms.

The facilitators of the programme then contacted the eligible participants to explain the study. Following this they sent me a document listing the carers who agreed to participate, with the contact details for each, and the type of carer they were i.e. non-relative or kinship. I then posted the information sheet (see Appendix C) and a consent form (see Appendix D) to each of the carers listed.

Once carers had returned their consent forms I contacted them by telephone to answer any questions they had where appropriate, and to organise a time and location for the interview. Participants were given two choices regarding the location of their interview, which were described clearly on the information sheet. One possible location was a private office space outside of the home and location of the training programme. An alternative location was at their private home. It was recommended that children were not present at the interview to ensure their privacy and protection, as well as to prevent any response bias. An interview time was therefore made when the carer's child/children were at school or when caregiving arrangements could be made.

The interview. In keeping with the IPA approach, a semi-structured interview was used each running for approximately 90 minutes (Smith et al., 2009). The interview schedule was guided by a set of broad topics each with a related open-ended question. The sequence of these topics/questions was flexible and allowed for the natural flow of dialogue between the participant and myself. The interview was led to some extent by the participant, but with the scheduled topics still in mind. This allowed for issues to arise that were important to the participant (Howitt, 2013; Smith et al., 2009). The interview schedule was revised after the first interview. It is noted on the original interview schedule (see Appendix E) which parts were removed, and it is noted on the updated schedule (see Appendix F) which parts were added. My supervisors and I decided to remove the topic on carers' experiences participating in the training programme (e.g. how they found the location and timing etc.) and the topic on carers' fostering experiences during the 12 weeks they attended the training programme. These topics were not specifically related to the research question, and it was felt that the interview needed to focus on those which were more directly relevant. The key three topics, for the most part, remained unchanged. Under each broad topic was a set of sub-topics/probes that were checked off throughout the interview. For one particular topic there was also a set of subsidiary questions.

The following broad topics/open-ended questions, guided the interview:

- Topic 1: "Tell me about your history of providing foster care."
- Topic 2: "Tell me about your fostering experiences after completing the Fostering Changes programme".
 - Initial/over time/current.
 - Probes: Caregiver, child, child-carer relationship, family, placement disruption.
 - "What aspects of the programme had the biggest impact on your fostering experience?"
 - "What challenges do you continue to face/experience?"
 - "What would things be like for you and your family if you hadn't of attended the Fostering Changes programme?" (to ask last)
- Topic 3: "I would really like to hear about your perspective regarding training for foster carers and how it should be run/how you think it should be."

The aim was to encourage the participant to open up and provide lengthy and detailed descriptions of their experiences (Howitt, 2013; Smith et al., 2009). For this to occur time was given for an introduction and a rapport building phase to enable the participant to feel safe and comfortable, and so that they had a good understanding of how the interview would run. Following recommendations under the IPA procedure, the participant was informed of the purpose of the interview, which was to gain as much information as possible regarding their experiences, and that consequently they may be probed by the interviewer to elaborate on or clarify some points (Smith et al., 2009). The interview was recorded using an audio-recording device. This is recommended to allow the interviewer to be actively engaged throughout the interview (Howitt, 2013). As recommended by Smith et al. (2009) to help facilitate the bracketing of preconceptions, I always tried to focus my attention solely on the participant and listen closely to what they were saying.

At the end of the interview the participant was thanked and given a small gift for their participation. They were then reminded of who to contact if they felt at all distressed or concerned with some of the issues raised during the interview, or if they had any questions regarding the study. This was also clearly outlined in the information sheet provided before the interview. Each interview was transcribed verbatim but excluded extra-linguistic features such as the lengths of pauses, pitch and speed of speech, which are required for conversational analysis (Howitt, 2013). Participants were offered a copy of the transcript. Interviews were transcribed through a transcription service due to the length of the interviews and time constraints. Ideally I would have undertaken this to help familiarise myself with the data. However, I made up for this by re-reading and listening to the transcripts. It should be made clear that the local organisation that facilitated this study were not involved in the interviews and did not have access to any of the interview transcripts. The interviews were carried out over two months which is why the follow-up period outlined in the research question is between 13 and 15 months post training.

Data Analysis. The following steps of data analysis followed those outlined by Smith et al. (2009). According to Smith et al. (2009), there is no right or wrong approach to carrying out IPA analysis. The process is flexible and multi-directional. These steps are therefore not a prescriptive approach. Rather, they are a set of guidelines to make analysis more manageable and less overwhelming for researchers new to IPA.

It should be noted that steps 1-3 were completed for each participant/transcript before moving on to the next. It was important to try and bracket the themes which emerged from the first case when analysing the next one. By following the systematic steps of analysis this

helped to facilitate this bracketing process (Smith et al., 2009). All analysis was completed electronically using Microsoft Word.

Step 1: Familiarisation with the data and initial noting

This first step involved becoming immersed in the data by re-reading and listening to the transcripts of each participant. The purpose of this stage was to become as familiar with the data as possible. Notes were made on the right-hand margin of the transcript which consisted of any initial thoughts or observations regarding the text. Sections of the transcript were highlighted that were believed to be particularly important or interesting. There are no rules regarding how these notes should be made, but Smith et al. (2009) provides three types of exploratory commenting that are useful during this stage of analysis: 1. Descriptive comments: regarding the content of the transcript e.g. key objects or events described. 2. Linguistic comments: how language is used to reflect this content e.g. repetition and metaphor. 3. Conceptual comments: asking questions of the text and coming up with initial interpretations (Smith et al., 2009). Each of these was considered when writing the exploratory notes.

Although not included in the steps outlined by Smith et al. (2009), a separate document was created for each transcript that contained further notes. There were some sections of each transcript that I found particularly complex and/or important for which I believed the exploratory notes were not sufficient. In this document a comprehensive, fluid summary of these sections was provided, which was an interpretation of what the participant was trying to convey but which stayed close to the original transcript and exploratory notes. It was felt that these summaries ensured the full context was captured, and were easier to read and understand for some parts of the transcript than a collection of disjointed exploratory notes. Some of these summaries connected different parts of a transcript where the participant was speaking about a similar idea or outcome. Each summary referenced the relevant page numbers of the transcript.

Step 2: Developing emergent themes

During this stage I began to draw connections between the exploratory notes to identify themes. Each theme was a concise phrase that captured the sections of the original transcript, and the exploratory notes. These themes were written down the left-hand margin of the transcript, opposite the relevant sections of the transcript and exploratory notes. During this process I continued to revise and add to the exploratory notes if I came to interpret a part slightly differently than before, or felt that further description was needed.

Step 3: Searching for connections across emergent themes

For each transcript I began to analyse the connections between the emergent themes. Those themes which were related i.e. reflective of a similar concept or outcome, were grouped together to create a superordinate theme. A new name was given to represent this cluster of themes. All emergent themes were listed (using bullet points) under this superordinate theme and the transcript page numbers in which they appeared. In some cases an emergent theme itself came to represent a super-ordinate theme. Throughout this process I would always read through the original transcript and exploratory notes again, as well as the separate document containing summaries, to ensure that these themes were reflective of the data.

Some emergent themes were able to fit under multiple super-ordinate themes (i.e. could be placed within different clusters of themes). This is because these super-ordinate themes are not distinct categories, and instead overlap. I decided to place such themes under each relevant super-ordinate theme, but highlighted these in red and made a note beside each, indicating its repeated use. At this stage of the analysis I wanted to maintain openness and flexibility regarding the organisation of themes.

Step 4: Searching for connections between themes, across cases

Once steps 1-3 had been completed for each transcript, step four was carried out. This involved analysing connections between themes across the different cases. The similarities and differences between the themes were considered. Themes were shifted back and forth into different clusters until a final draft of super-ordinate themes had been produced. During the writing of the results chapter the grouping of themes was revised until the thematic structure appeared to capture my interpretation of the data.

Rigour and trustworthiness. Four principles for assessing the quality of qualitative research were developed by Yardley (2000). These are: *sensitivity to context*, *commitment* and *rigour*, *transparency* and *coherence*, *impact* and *importance*. Smith et al. (2009) describes how each of these principles can be met in IPA research. These were considered in the current study.

One way that *sensitivity to context* was demonstrated in this study was through the interview process, during which I was always aware of, and made an effort to, build rapport with the participant, put them at ease, show empathy, and attended closely to what they were saying. This also demonstrated *commitment* to the IPA interview (Smith et al., 2009).

Sensitivity to context was also shown through the inclusion of a substantial number of verbatim quotes in the results chapter to allow carers' voices to be heard (Smith et al., 2009).

Peer debriefing and supervision were used to ensure that the data analysis procedure was systematic and thorough. This therefore demonstrated both *commitment* and *rigour* (Smith et al., 2009). During peer debriefing a section of transcript was given to a student (Master's student in the same field of study: Child and Family Psychology), who wrote their own exploratory notes. It should be noted that all identifying information was removed from the transcript before it was given to the student. The similarities and differences between the student's notes and my notes were then discussed. Further, throughout the data analysis process I would at times discuss with the student my interpretations of specific sections of transcript. Both of these procedures allowed me to become more aware of my presuppositions and to consider alternative interpretations. I also met with my supervisor frequently to show them my written analysis of the data, discuss any challenges I was having, and to check that the process was being conducted thoroughly. As with the peer debriefing process, supervision was also used to help me make sense of and question the interpretations that I was making.

Transparency and coherence have been shown in the current study. The steps of the research method are described clearly and in detail, therefore demonstrating *transparency* (Smith et al., 2009). The fit between the research and the principles of an IPA approach demonstrates *coherence* (Smith et al., 2009). A range of methodologies were considered to ensure that the one chosen was the most appropriate fit. The three key theoretical underpinnings of IPA (phenomenology, ideography and hermeneutics) are written up in detail in the method chapter. Supervision was used frequently to ensure that these were clearly understood and were being considered carefully throughout data collection and the analysis procedure.

Lastly, I believe that the principle of *impact and importance* has been met. This research addresses an important gap in the literature and provides useful information that will help to inform policy development and the future development of training programmes for carers.

Ethical considerations. Several important ethical issues were considered for this research. Participation in this study was voluntary, and participants were able to withdraw from the study up to two weeks following the interview. Children were not present at the interviews. This was to ensure their privacy and protection, as well as to prevent any response bias. To avoid any implications of coercion and response bias, interviews were not held at the

offices of the Canterbury organisation which ran the training. Moreover, participants were made aware that the organisation were not involved in the interviews and were not able to view the transcripts.

To ensure anonymity pseudonyms have not been used in the writing of this thesis. This is because all participants were from the same training group and therefore knew one another. Participants and facilitators may be able to piece together the different accounts of a participant presented in the results chapter, and determine which carer is being referred to despite being represented by a pseudonym. Therefore, instead of a pseudonym, the following phrases were used: 'one carer stated', 'another carer explained', 'they said'. Further, their children's names have not been mentioned in the thesis.

There was the potential for participants to experience some distress when reflecting on and describing their experiences with foster care. To minimise the risk of distress, interview questions were worded sensitively, participants did not have to answer certain questions if they did not want to, and they were provided with the opportunity to withdraw from the interview at any time. Further, as outlined in the information sheet given to them, participants were offered a referral to an appropriate support service if they experienced distress. The Canterbury organisation which ran the training agreed to provide such services if needed. If participants wished to seek help elsewhere, alternatives were able to be discussed with my supervisors and other Child and Family Psychology staff at the University.

Ethical approval for this study was given by the Human Ethics Committee at the University of Canterbury with approval number HEC 2015/50 (see Appendix G).

Chapter 4: Results

The data obtained from the semi-structured interviews were analysed, and from this five superordinate themes were identified. Subthemes were identified within three of the superordinate themes.

Summary of Results Chapter

Superordinate Themes and Subthemes

1. Fostering Changes was a beneficial training programme
 - a. Positive perspectives on the programme
 - i. General and content focussed
 - ii. Benefits of the group format
 - b. Positive impacts on caregiving competencies
 - i. Greater insight into their child's behaviour
 - ii. Increased emphasis on attending to positive behaviours and using praise
 - iii. Improved regulation of emotional reactions
 - iv. Increased patience and acceptance
 - c. Positive outcomes related to improved caregiving competencies
 - i. Improvements in the child-carer relationship
 - ii. Placement stability
 - iii. Transferring skills to other family members
 - iv. Improvements in some of the child's behaviour
 - v. Reduced stress
2. The need for further professional support post training
 - a. Carers' involvement with other support services
 - b. Support needs to be multifaceted
 - c. The desire for continued support from Fostering Changes post training
 - i. A follow-up for support with new or ongoing challenges
 - ii. A follow-up to refresh memory
 - iii. Additional support directly post training
 - d. The need for training and/or professional support in the *future*
 - i. You can never have enough training
 - ii. The desire for *specialised* future training and/or professional support
 - iii. Future training for a different child in the family

3. The challenges of fostering continue
 - a. Caregiving is an ongoing struggle
 - b. Experiencing a crisis point
 - c. Continuation of the child's difficulties
 - i. Continuation of the child's felt insecurity within the placement
 - ii. Ongoing behavioural difficulties
 - d. High stress levels remained
 - e. Negative impacts of placement breakdown on family wellbeing
 4. Variability in carers' confidence
 5. Training for carers is important
-

Each of the five superordinate themes and the sub-themes are described in detail in this chapter. Quotes from the interviews are used to illustrate each theme and to allow carers' voices to be heard. These themes should not be read in isolation as they are not distinct categories. Given the complexity of these carers' experiences, these themes are, in fact, all interconnected.

It should be noted that the pronouns 'she' and 'her' will be used throughout the results chapter, even when referring to the male carer. This is to protect his anonymity given that he is the only male participant in the study. This does not impact the analysis as no conclusions were drawn regarding the differences between the experiences of males and females. This is in part due to the small sample size and the qualitative nature of the study.

Theme 1: Fostering Changes was a beneficial training programme

This theme highlights the positive impacts the Fostering Changes programme had on these five carers. They all spoke of the programme as being a valuable experience which had improved their caregiving skills in some way.

(a) Positive perspectives on the programme. All five carers spoke very positively about the Fostering Changes programme. This included general comments relating to the overall value of the programme, as well as positive responses regarding its content. Carers also commented on the benefits of the group format.

(i) General and content focussed. Carers commented on how they found the course very valuable, as evidenced in the example statements below:

"I found the course really, really, really useful."

“I think it’s a great programme, I thought it was fantastic.”

One carer mentioned that she had recommended the programme to a family member who was having difficulties managing her children’s behaviour. This carer also lent her Fostering Changes folder (which contains notes from the programme) to a friend who was experiencing challenges with parenting. Given the positive impacts the programme had on her own caregiving, she believed it would be of benefit to these parents.

“I even lent my folder to um a friend of ours because they just recently got married, so they’re bringing in two different families.”

Another carer explained how she thought the Fostering Changes programme is not only beneficial for foster carers but biological parents as well.

“I would actually think that would go a little bit further and most parents, they would benefit from it.”

All five carers spoke highly of the programme’s content. One carer expressed how she thought the content was “*excellent*” and was very relevant to the issues that carers experience.

“I thought it was really good, really relevant to the, you know nitty gritty of caregiving.”

Another carer also commented on how she thought the Fostering Changes programme was more applicable to her child’s complex difficulties compared to other courses she had attended which she believed were more designed for parents who had children with less severe types of behaviours. Moreover, one carer also discussed how she really appreciated the content on child development, including the impacts of trauma on development. She explained that it would have been useful if the CYF training she attended a few years ago, in preparation for becoming a foster carer to her other child, had included this content on development.

(ii) Benefits of the group format. In addition to finding the course content very useful, all five carers discussed how they found the group dynamic very beneficial, including the sharing of ideas and experiences between the carers. They described how it was helpful to hear that other carers were experiencing similar issues to themselves. As one carer explained, this meant that she no longer felt alone in the difficulties she was experiencing.

“...having the knowledge that you’re not the only person sort of doing this or having the struggles.”

For another carer, hearing that others were having similar experiences with their foster children meant that she was able to normalise her child's behaviours, and it provided her with reassurance.

"I think the discussion [with] the others, and hearing that everybody else was having the same issues, that just made me think oh, ok so it's not just the way that we're dealing with this, or the way we're treating [child's name], um I think that just made me feel oh ok, no we're doing ok, this is just what we've got to expect."

Three carers also mentioned how it was helpful to get ideas from the others in the group on how they were dealing with certain issues. As one carer stated:

"Hearing other parents talk about, foster parents talk about how they were responding and doing things. There was, you know, there's a richness in the sharing of those experiences and I appreciated that."

Another carer explained that while professionals are very knowledgeable, other foster carers are able to contribute a level of knowledge based on personal experience that professional may not have.

"And unless you've done, done this yourself even, even, professionals have got all the knowledge but even sometimes they don't have the answers, so sometimes you can just get answers from yourself, from other people."

For one carer, participating in the group helped to improve her interpersonal skills and confidence participating in a social setting. She explained that she would not be sitting here speaking with the researcher today if she had not completed the programme.

"We wouldn't be having this conversation."

This is because she finds it difficult engaging with people she is unfamiliar with.

"...I don't deal with um strange people very well."

She explained that over time she was able to open up and become more comfortable engaging with others in the Fostering Changes group. She described that what helped was that all the carers in the group shared similar experiences and were not judgemental of each other.

“...it was actually a big step for [me] to actually go into the group and, and I at first I was very quiet and I didn’t participate a great deal umm, but then I thought well ok, and I just let it all out.”

Further, she explained that the programme facilitators helped her to come out of her shell, in particular when they demonstrated the role playing exercises.

“...it helps cause if they can sit, if they can be in a room and make complete idiots of themselves then so can we and um cause I’ve always been a paranoid person about making a fool of myself.”

(b) Positive impacts on caregiving competencies. All carers spoke of the positive impacts that the Fostering Changes training programme had on their caregiving competencies. The positive changes in competencies discussed by the carers were those they had continued to implement since completing the programme, and which they still apply currently.

(i) Greater insight into their child’s behaviour. Three carers discussed that through the programme they developed a greater understanding around their child’s level of functioning and development, and why they behaved in certain ways.

One carer explained that she became more aware of the impacts that trauma can have on child development.

“I guess um before the course, I didn’t realise how big of an impact, um some of the situations, I mean, I guess some of them I did like sexual abuse. But just the neglect and the emotional abuse I didn’t realise how big of an impact that had on him, and how all the developmental stages, yeah sort of all those early brain connections and early brain development, so definitely doing the course, that helped me understand a lot more...”

Further, this carer also spoke of how the discussions with other carers in the group improved her understanding of her child’s behaviour and made her realise that what he was experiencing was “normal” given his past caregiving experiences.

“...just that this is what is normal...for a kid with these sorts of background, that’s totally normal.”

She also explained how the programme gave her a better understanding for why her child was functioning at a low level and had difficulty with basic tasks. This increased understanding of

child development is something she believes she has carried with her since completing the programme, and which currently impacts how she parents.

“...so the course was great for um teaching me those developmental steps and the impact of not having those developmental steps.”

Two carers explained that their increased understanding of their child was one of the biggest impacts the programme had on their caregiving.

“...just remembering that, the background that he’s had and the reason why he’s, or trying to understand why he’s acting out the way he is.”

For one of these carers, this increased understanding of their child led to a change in their approach to behavioural management. Rather than controlling the child’s behaviour through applying consequences, she considers what might be driving this behaviour and then tries to address this underlying cause.

“...before the course we probably looked at umm, controlling the behaviours and now we look, so why is he doing that, and actually take the cause away.”

The carer provided a recent example of how she has applied this increased understanding to change the way she manages the child’s behaviour when they go away on holiday.

“...if you go to a new place, yeah, he will, it will, he will feel very unsafe and he starts to act out....so if you think of it that way, so there’s not much you can do with consequences because he feels so ahh, so anxious that umm, yeah, he won’t be influenced by consequences.”

(ii) Increased emphasis on attending to positive behaviours and using praise. One carer explained how participating in the Fostering Changes programme led her to make changes to her behavioural management strategy, from focussing mostly on applying consequences for negative behaviour to incorporating more praise for positive behaviour. This included focussing on those opportunities where praise could be given. She described how this increased use of praise, as emphasised in the programme, has worked really well as a strategy, and that she currently still uses this on a daily basis.

“So, and what the course has done ahh, to us is actually umm, yeah, teach us to focus a little bit on the positive stuff, yeah.”

Similarly, two other carers also spoke of their changed behavioural management approach to include greater acknowledgment of positive behaviours and the use of praise,

which they have continued to use over time since completing the course. As one of these carers stated:

“...one of the big things was always trying to remember to praise the positive and that was something that really stuck with me in the course...”

This carer described how she will now focus on what is positive about a difficult situation, such as highlighting what the child was doing well, rather than dealing with the negative behaviour. In fact, she mentioned that this was *“the biggest thing that [she] got from the course”*.

(iii) Improved regulation of emotional reactions. One carer explained that prior to completing the Fostering Changes programme she expressed a lot of anger when communicating with others, including her own children. Through engaging in the role-playing exercises in the programme, she realised that this was not an appropriate or effective way of communicating

“yea a hell of a lot of anger actually, um whereas doing the role playing it was like wow I shouldn’t really be talking like that should I.”

She described that since completing the programme she has changed the way she responds to her child. She is able to regulate her negative emotional reactions and speak to her in a calm manner rather than with anger. She believes this is something she currently still implements.

“Before it would be I’d just yell and scream the minute I was starting to get frustrated I would yell and scream before I did this course nooowww it’s like I don’t want to deal with you right now so I’m going to walk away and I’ll walk away and calm myself down and then come back and go right we need to sit down and talk about why I did what I did and why you are being disciplined.”

After improving her own emotional regulation skills, in particular controlling her anger, she felt that she was then able to teach her child ways of recognising and managing her own emotions.

“...because I’m recognising um my emotions I found it easier to help [child’s name] recognise hers, um like she gets upset and she thinks that she’s doing something wrong and it’s like well no you are entitled to get upset but um ya it’s ok to be angry but it’s not ok to take it out on everybody else.”

(iv) Increased patience and acceptance. Three carers discussed how after completing the Fostering Changes programme, they became more accepting of their child's behaviour and level of functioning, and had developed a greater level of patience.

One carer explained that prior to completing Fostering Changes she was very intolerant of her child's difficult behaviours, and would become frustrated that they did not seem to be improving.

"...previously I might've thought, ohh, you know this, it's never going to change. It's hopeless."

Through attending the course she realised that some of these behaviours are "*probably never going to change*" and that she just has to "*accept that this is the kid she is*". She described there being a shift in her perspective: rather than trying to change her child's behaviour she needed to instead change how she responded to it. She explained that Fostering Changes gave her the time and space to reflect on her caregiving practices and ways these could be changed. Additionally, it helped hearing the experiences of other carers and ways in which they responded to their child's behaviour. She realised that she needed to accept *all* aspects of her child.

"...that this is the wee package she is. And umm, it's no use, I'm not going to change it."

"...I think that having the time on Fostering Changes to think about, okay, that is the reality. Yes, it is. It's who, it's the package...I've got to change something about how I manage it."

She described how she currently responds to her child's difficult behaviours with more patience and acceptance.

"...I'm more mindful, much more conscious that it's no use me blowing my stack or getting impatient because that doesn't work..."

Two carers explained that through understanding more about the causes of their child's behaviour they were subsequently more accepting and tolerant of it. One of these carers provided a recent example of this:

"...when he tripped [her] up and when he catapulted her off the trampoline the other day, you just think well no that's ok, that just [child's name]. Accept him for what he is, where he's come from and where he is now."

For this same carer it also meant that she changed her expectations regarding what her child was capable of, and she became more patient.

“Yeah I mean patience, yep, and a lot more taking things right back to the beginning, explaining everything right from the beginning, and not expecting him to understand everything.”

This is something she continued to think about and implement over time after completing the training.

“I mean I think that was just an ongoing thing again that was always in the back of my mind, he hasn’t had those experiences, he hasn’t had what he’s needed so we just need to take this really slowly, and not get frustrated with him when he can’t do what even [name of biological child] could do, yea we had to just, wait and wait, and the day will keep going and we’ll just keep waiting.”

(c) Positive outcomes related to improved caregiving competencies. All carers discussed the positive impacts their improved caregiving skills had on themselves, their child and/or other family members. It must be noted that this theme should not be read in isolation of theme three which discusses the ongoing challenges of caregiving. For example, as outlined in this theme, some carers described how their levels of stress had reduced and aspects of their child’s difficult behaviours had improved, which they believed were in relation to their improved caregiving competencies. However, as outlined in theme three, all carers spoke of how aspects of their child’s difficulties remained after the course, while the majority also discussed how their stress levels were still high or remained unchanged. This highlights the complexity of these carers’ experiences and their children’s level of functioning.

(i) Improvements in the carer-child relationship. One carer felt confident that by responding to her child in ways which demonstrated a greater level of acceptance and tolerance, their relationship had become more harmonious.

“...it’s enhanced it. Of course it has because we’re more attuned in those moments...”

“Well it’s enhanced our relationship because rather than being frustrated with her, I’m attuned to her and meeting her needs and hopefully there’s some healing in that for her in that repeatedly she gets to know that here again is a consistent, secure

response that accepts ummm, me for, you know, the unique wee character I am and it's not someone who's rejecting me..."

This carer provided an example of how she has changed the way she responds to her child's difficult behaviour, which has meant that these interactions are now a lot more positive and enjoyable for them both.

"And now when she umm...squeaks, she then, she makes all these you know funny movements, so now I just take over and I do the movements so I, she begins to squeak and I go (models movements) and she just bursts into laughter. It breaks the moment completely."

Another carer also explained that her increased level patience as a result of having a greater understanding of their child's development and causes of behaviour, in addition with her increased use of positive reinforcement, over time had a positive impact on how their child perceived them as carers.

"He saw I was more patient, yeah um, more encouraging...and he could see that we cared about him because we were prepared to sit there if it took all day...yep um. Yeah and that he slowly learnt to trust us, and to be able to come and ask us to help him."

(ii) Placement stability. One carer described how the skills and understanding she acquired through the Fostering Changes programme, made a small difference but it was nevertheless very significant because it meant that she has been able to continue fostering.

... "that's quite something, yeah, so, because if, if we hadn't done the, ahh, the course then ahh, ahh probably we would've struggled to continue. So it's actually yeah, it sounds like it's a little bit, but it's actually quite a big thing."

"Yeah, it's quite possible that we wouldn't have made it, yeah."

Particular skills she learnt through the programme that contributed to the continuation of the placement were *"understanding where [the behaviour] comes from, yeah...and better ways to, yeah, deal with it."*

(iii) Transferring skills to other family members. Two carers spoke about how they had applied the skills they had learnt on the programme not only to their foster child but to other family members as well. For example, one carer described how her communication with her husband had improved since completing the programme. She explained that she

learnt how to better regulate her emotional reactions and communicate in a calmer manner with less anger. She applied this not only to her child but then also to her husband. She explained that she is now able to communicate her feelings more openly to her husband, and attributes this to what she learnt on the programme.

“Even talking to the husband is a lot easier than what it used to be.”

“...cause the programme was a lot on communication um which was the first thing that we talked about and stuff um that so yeah learning to communicate with other people and letting other people know how you’re feeling was um a huge um thing.”

One carer described how she has applied the changes in her behavioural management approach, which includes a greater emphasis on positive behaviours and the use of praise, to her other two children as well as her foster child.

“Um, yeah, I mean also with our other two, I mean it is a good strategy.”

This same carer also discussed how due to her increased understanding of child development and the impacts neglect can have on developmental outcomes, she has placed a greater emphasis on ensuring that she gives her other foster child (the youngest) the stimulation and attention she needs to develop optimally. She explained that she started to make this her priority after the placement ended approximately 10 months post-training, as it meant she had more time to spend with her.

“...it’s making sure that she’s not overlooked now and that she does actually get that specific time to do those things that are age specific for her...”

“...whether it is to sit down and do jigsaw with her or whether it’s just to sit down and count the spoons or those types of things...”

(iv) Improvements in some of the child’s behaviour. Two carers spoke of the positive impact that some of the Fostering Changes strategies had on aspects of their child’s behaviour. One carer explained that the strategies she learnt, including how to pre-empt her child’s difficult behaviour, as well as placing greater emphasis on positive behaviours and the use of praise, contributed to a reduction over time in her child’s tantrums. This in turn had a positive impact on the wellbeing of the family as it improved the quality of time they were able to spend with each other.

“Yeah, um and trying to manage the positives um all those sorts of things reduced the amount of tantrums that he had, um so I mean that was a huge impact on the family, um, yeah.”

The other of the two spoke of a period during which her child’s behaviour escalated and became very difficult to manage, but that her consistent use of some of the Fostering Changes strategies throughout this time helped to reduce the severity of her child’s behaviour in the long-term.

“And then that’s when it just went umm, crazy...and then I guess because I’ve been consistent and kept the strategies going...I guess he’s now sort of back to [just] being challenging.”

One of these strategies was the ongoing use of positive reinforcement.

“...probably a big part of it is that he’s getting umm, the ongoing positive reinforcement helps, and I think that’s one of the things umm, also from Fostering Changes is umm, just, yeah, the ongoing positive stuff...”

(v) **Reduced stress.** One carer explained that by responding to her child’s behaviours more positively, i.e. with a greater level of patience and acceptance, some of her stress around caregiving subsequently decreased. Since completing the training, she very rarely reacts in ways which cause her to feel guilty and therefore stressed about her caregiving ability.

“I think my stress generally has reduced in relation to having [child’s name] because in those moments, rather than doing and saying things that I might regret later and think oh I was a bit hard on her, that has very seldom occurred, so umm yeah, it’s, and those moments it really did tip me.”

Similarly, one carer also described how her stress levels after the course comparatively reduced. She attributes this to a greater understanding of the causes of their child’s behaviour which meant it became easier to accept and manage.

Another carer explained that by gaining a better understanding for why her child behaved the way he did, and that this was ‘normal’ given his past caregiving experiences, it relieved her of the personal responsibility for his level of functioning which helped to reduce her stress.

... *“the course really helped us to understand why [child’s name] was the way he was, that it was going to be long battle and that we just had to ride it out, um and that the things he was experiencing were normal. And so that took a huge weight off our shoulders.”*

Moreover, this increased understanding of her child’s functioning enabled her to notice and appreciate the small milestones he achieved, which also led to a reduction in her levels of stress.

Theme 2: The need for further professional support post training.

All five carers described their use of, or desire for, further professional support after completing the Fostering Changes training programme. Despite the positive impacts the programme had on their caregiving competencies, they identified that further support is needed. This theme suggests that given the challenging nature of their role, while the Fostering Changes training is valuable, it is not enough on its own to provide these carers with all the support that they need.

(a) Carers’ involvement with other support services. Four carers mentioned their involvement with some other form of professional support in the 13-15 month period following training. The carers’ accounts indicate that they wanted further targeted support for their child’s behaviour and/or mental health, which was beyond what they could provide given their level of competency.

One carer described that soon after the Fostering Changes programme, she organised through Child, Youth and Family (CYF) for their child to see a play therapist due to the child’s self-harming behaviours. She stated that their child is still currently seeing the play therapist once every three weeks. The carer expressed their difficulty in trying to understand and manage these types of behaviours and therefore why the therapist needed to be involved.

“It’s really hard umm, as a caregiver, that’s one of the few areas that are really hard to deal with...because that comes down from so deep, yeah, so and we really, and you really need to understand him really well and why he’s doing that, so, so that’s why we got the play therapist.”

Throughout one carers’ account, she spoke of the severity of their child’s difficulties, the high level of care that he required and his need for specialised support. This carer discussed how their child underwent multiple assessments at a child mental health service

both before and after Fostering Changes, which included occupational, and speech and language assessments. Given the severity of the child's difficulties, this service referred the child for more Intensive Case Management (ICM) support. ICM provides coordinated care plans for young people who require the involvement of multiple services (Canterbury District Health Board, 2013).

Similarly, another carer also discussed how her child very recently received assessments at a child mental health service regarding her anxious behaviour and that both she and her child will be receiving their support. As discussed in a later section, this carer plans on attending a training course on 'parenting anxious children' at this service.

One carer mentioned that she had attended a CYF training module for "*teenagers in care*" about a month prior to the interview, and also received support from Multi Systemic Therapy (MST) about six months prior. She explained that she sought support from MST due to her child's "*ongoing behavioural problems*".

"...yeah I, I guess the thing is that the Fostering Changes was really good. It's just, I guess sometimes it's, or for [child's name] in particular, it's just that you feel like we do things and we implement them but it's never quite enough to, to get his behaviour."

MST is an intensive therapeutic intervention that targets those young people with serious externalising behavioural difficulties, and is delivered in the natural environment in which the child spends their time e.g. school, home. The clinician works both with the young person and those people who are important in the child's life e.g. teachers, caregivers, and community members, to provide them with the support and skills they need (Multi-Systemic Therapy New Zealand, 2003). This carer explained that the benefit of MST is that that they come in to your home, and are therefore able to get a good sense of the situation, her caregiving skills in action, and the child's behaviour, and can provide one-on-one support.

"...as opposed to going in and doing something like Fostering Changes and umm, the adults there don't know the kids and they don't know their temperaments [whereas] these people do because ...they hear what we're saying and, and it's more of a one-on-one type situation as opposed to a group..."

(b) Support needs to be multi-faceted. One carer discussed how she thinks her caregiving skills are not sufficient on their own to cause changes in her child's behaviour, and that Fostering Changes is only one part of the overall support system that is required. She

believes that support needs to be coordinated across different settings, for example the home and school.

“But I think it’s a, it’s, it’s not about just what we’re doing. It’s a, it’s an overall picture because the school, I mean they, they make a big difference in what happens to [child’s name] and his behaviour, umm, and all the other things that are going on so it’s, it’s probably not just about what we’re doing at home.”

This carer also explained how although she thought the Fostering Changes programme was very helpful, it has been the combination of different trainings and support she has received which has led to positive changes in her caregiving and child’s behaviour. In regards to Fostering Changes, she believes that:

“It’s not everything but it’s one piece of what’s helped.”

(c) The desire for continued support from Fostering Changes post training. Three carers expressed interest in receiving some form of further support from the Fostering Changes group after the 12-week training course. Two types of continued support were identified. The first was a follow-up after a substantial period of time had elapsed since the programme (e.g. several months or a year) to receive support for new issues they were struggling with and/or to refresh their memory of strategies they have forgotten. The second involved additional support directly after training that went beyond what was provided in the programme.

(i) A follow-up for support with new or ongoing challenges. Two carers mentioned that they thought attending a follow-up would be useful to help with issues that were not present or prominent during the time of the programme, or issues that they have continued to struggle with. One of these carers suggested the following:

“It would be good to do some kind of follow-up, maybe with the course. So after a year, get everybody together all at once and actually say, okay, so what issues have now been solved since and, ahh so what, what issues are you still facing and then just checking in and ahh, yeah, give people a little bit of recommendations going forward again.”

This carer explained that a follow-up would be useful to provide them with some guidance on a new and current issue they are struggling with:

“Um, yeah, probably because, so this issue, we didn’t really have that umm, when we did the course but umm, now we do and yea, probably yeah, they would give us some, some answers.”

The other of the two carers thought that a follow-up with Fostering Changes perhaps three or six months post training would have been beneficial to help with new issues that cropped up or those that were put to one side as she focussed on the more prominent ones at the time.

“As time progresses, you’ve sort of dealt with those issues and you’re sort of moving on to different issues.”

She went on to provide an example of a challenging situation at the beginning of the year that she had not experienced during the time of the course that she felt she needed support with. This was around the child’s contact with his biological father:

“CYF’s said well you’re to ring this number and [child’s name] is to talk to him. And I mean we didn’t know how to talk to [child’s name] about that, or deal with that.”

Further, this carer expressed that there may have been some content in the programme that she did not attend to as it was not a prominent focus for her at the time but which is now more applicable to her situation:

“I’d very happily go on a one or two day run through again...I mean you might have missed something or, as I say the situation might be slightly different so you may pick up on some comment that is more relevant today than it was 12 months ago.”

(ii) A follow-up to refresh memory. Two carers expressed an interest in attending a follow-up with the programme to remind themselves of the strategies and skills which they may have forgotten. One carer described that due to the intensity of the training, the skills that were taught became ingrained. She has continued to use them over time but they are no longer explicitly remembered. She believes that a follow-up would provide a recap to refresh her memory and to keep her on track, as she has not been referring back to the course notes. She also mentioned that it can be helpful to have a follow-up to remember those strategies which after the programme proved ineffective and were therefore discarded and forgotten, but which might become useful later on.

“That’s where a recap is quite good because you then actually take the time to actually go over things again.”

Unlike this carer, the other of the two explained that she will very occasionally look at the course folder and will be reminded of some of the strategies and skills taught. She thinks however, that a follow-up would be easier than trying to re-read the notes.

“I thought it was fantastic, um whether there can be sort of a refresher type thing of it that you do a year later, or you do once a year, sort of a refresher.”

Moreover, this carer liked the idea that if these follow-ups continued at regular intervals over time, then the content would be altered in order to be relevant to the child’s changing developmental level.

(iii) Additional support directly post training. Two carers expressed their desire for some form of extra support from the group post training. One carer described how it would be useful to set up a Facebook page after the programme to remain in contact with both the facilitators and participants of the training group. This would mean ongoing support would be accessible to carers like herself who had limited time or money to travel to training groups.

“To communicate with these people and maybe the tutors ahh, but it was via Facebook so that you know, you’re still asking questions, you’re still moving forward.”

The other carer explained how she thought she would have benefited from a one-on-one with the facilitators of the programme post training to discuss in more detail some of the difficulties she was experiencing and ways of managing these. She felt that she could not discuss some of her personal circumstances in depth during the programme because it was a tight schedule and she did not want to take away the time from other carers who also wanted to share with the group the difficulties they were experiencing.

(d) The need for training and/or professional support in the future. All five carers expressed a desire to receive further professional support in the future. This included training and one-on-one professional guidance to improve their skills and knowledge as carers. One carer also mentioned the benefit of having a support person to work directly with their child. Further, some of the carers described specific areas they would appreciate support/training around. This included child anxiety, adolescence and dealing with issues around birth parents.

(i) You can never have enough training. Two carers firmly stated their belief that as a carer you can never have enough training.

“...I don’t think I would’ve ever had enough training really.”

One of these carers felt strongly that she could always improve her skills and develop more knowledge. She explained that attending more training is ideal but finding the time can be difficult. Given that time is an issue, she said that she will research on the internet, read books or speak with others if she wants to learn more about something. Further, she mentioned the possibility of attending a training course run by CYFS at some point in the near future, as they currently do not have the time to fit this in. She described the course as being similar to Fostering Changes but from a “*different perspective*”. When explaining why she would attend the CYFS training course, she stated:

“Because I think, yeah, knowledge is always good, yeah, so that just in general. So now, I’m I’m pretty certain they can ahh, bring us ahh, forward and they can progress us in, in some areas but yeah, you also need to find time for that.”

(ii) The desire for specialised future training and/or professional support. Three carers discussed their potential need for specialised training or support in the future which would target specific issues as opposed to it being general caregiver training.

One carer explained how she would continue to seek professional support in the future to ensure she is as competent as she can be in doing the best for her particular child. Given that training is a big commitment that takes up a lot of time, she would only attend training in the future that was particularly relevant to her child’s specific needs. This carer has organised to attend a “Parenting Anxious Children” training group:

“...that’s why I’ll go to Parenting Anxious Children at [name of mental health service] because it’s absolutely highly relevant to her needs.”

In addition to her child’s anxiety, this carer described that another specific and current challenge she would like to seek professional support around, is how to appropriately communicate with her child about her biological mother, including why she is unable to currently return back to her care. She envisioned that this would be in the form of one-on-one guidance from a professional rather than group training.

Similarly, another carer also thought that she would benefit from some form of training in the future around those challenges that come with helping the children build a positive relationship with their birth parents. This included developing a greater understanding of the difficulties these parents have been through and how this has influenced their current circumstances. Both she and another carer also expressed an interest in attending

some form of training in the future around dealing with adolescents. They explained that as their child enters adolescence their behaviours will become very different and that it will be important to understand what they are going through and how best to support them. As one explained, adolescence is a “*whole different ball game*”. Similarly, the other carer described the adolescent years as a very difficult period which she might need support for:

“Because of all the different peer pressures and stuff so I think so long as we’ve got support going through the teenage years, are the most important ones I think.”

This carer described two forms of support that could be useful during this time. One was caregiver training:

“...if they bought out a programme for the teenage years, I’d be quite happy to do that.”

The other type that she suggested was a support person that her child could seek advice from or talk to around issues that she did not feel comfortable discussing with them.

(iii) Future training for a different child in the family. One carer mentioned that it might be useful for her to repeat the Fostering Changes programme with her other child in a few years’ time, as she predicts that her behaviour may become more difficult as she gets older.

“I mean I’m sure there’s going to be lots of issues later down the track, and maybe it might be good to do the programme again when she’s sort of 8 or 9, and, and realising that she’s got another mother and why is she with us, and all those sort of questions are coming up, and no doubt those behaviours will come out.”

Theme 3: The challenges of fostering continue

Connected to theme two, which outlines the carers’ desire for ongoing professional support, is this theme on the ongoing challenges of fostering following training. This was discussed by all five carers.

(a) Caregiving is an ongoing struggle. One carer described improvements in their caregiving competencies and issues which had improved after the Fostering Changes training, but often followed this up with an explanation of how their role as a foster carer has continued to be very challenging. Even though this carer found the training helpful, it was to a limited degree.

“Yeah, and it sounds like we go, got it all worked out now, but it’s not the case because, we are, it’s just a daily battle almost...”

“I think the course has, helped us, but I can’t say that after the course that umm, that everything is, is hunky dory because it, yeah, the last half year, it’s been, been really tough...”

This carer described themselves as still being on a difficult journey which requires their endurance and patience. They still find fostering very challenging but what motivates them to continue is the prediction that at some point down the track things will start to get easier, and that they just need to persevere.

“...it’s a little bit like running, umm, a marathon or so. So when you do it, it’s it’s quite hard but, yeah, I think once, once it is completed, it will be worthwhile.”

They also mentioned that some days are more difficult than others and that during these periods it is *“just a matter of surviving.”* This suggests that things have been a real struggle and that they are only just managing to get by. Further, they discussed how caregiving is constant hard work. When they are not trying to manage their child’s difficult behaviours, they are trying to take any opportunity to instil positive aspects into their child’s life which is still demanding of their energy and time.

(b) Experiencing a crisis point. Three carers experienced a point of crisis in the 13-15 month period following training. For one of the carers, this crisis was experienced as a placement breakdown. This was due to both a lack of support from professional services, and personal resources to meet the child’s high level of needs. One carer experienced a period of significant uncertainty in her ability to continue caregiving, in part due to a lack of family support. The other carer spoke of a very challenging period when she struggled to manage her child’s severe behaviours. All carers mentioned that a lack of support, either from family or professional services, contributed to this point of crisis.

As outlined above, one carer experienced a point of crisis approximately 10 months after the Fostering Changes programme when she and her husband decided that the placement could no longer continue. A combination of factors led to this decision. One of these included the difficulties they experienced in trying to access the necessary support services needed for their child. Given that the placement was arranged through an informal whanau agreement they were not connected with Child, Youth and Family (CYF). Without

the involvement of CYF, they had limited access to the intensive and specialised support that the child required.

“And the only way that we could actually get the help he needed was to say to CYF’s that we couldn’t have him anymore, and then he’d be a child in need of care and protection, and that’s what’s happened and now he’s been able to get the intensive case management, the school’s been able to get more funding, and a lot more um RTLBs and all sorts....”

In addition to a lack of external support, this carer also described not having the personal resources to enable the placement to continue. Given the severity of the child’s difficulties, she described how caring for him was a very time-consuming and demanding role which as a result reduced the time and attention she could give to her other two children.

“...it was just too big of a situation...for me to handle...I just couldn’t spread myself wide enough over the three children to give him the quality of time that he needed and to manage the other two as well, and give them what they needed, yeah it was just too much...”

She felt that she could not give her child the one-on-one attention he required when she had three children to care for. In the end she felt that she needed to prioritise her other two children and “*do the best by them*”, which meant ending the placement.

One carer spoke of a period of significant difficulty approximately six or seven months after the Fostering Changes programme, which she felt had evolved from a lack of support from her family and husband. According to this carer, her husband felt that fostering was putting a significant strain on the family dynamics. This family conflict in combination with a lack of support from her husband, “*came to a head*” at this 6-7 month period post training which meant she came close to giving up her role as a carer.

“...there was a stage there um where we where I was going to ring the social worker up and say hey listen I can’t do this.”

She stated that at this time she felt she did not have support from her husband and felt very isolated in her role as a carer:

“I felt that he wasn’t fully on board and he wasn’t supporting me and I just felt like I was just doing it on my own.”

One carer experienced a significantly challenging period following the Fostering Changes programme when her child got excluded from his school due to severe behavioural issues. She explained that after being excluded his behaviours escalated at home including heightened physical and verbal aggression. She expressed having feelings of low self-efficacy during this time as she described not knowing how to manage the situation, and that she needed more support.

“...his behaviour really escalated and I, and I felt quite umm, just didn’t know what to do really, umm, and that was a really critical time and, and I had no help at all.”

“...when it was really hard is when he was excluded and that was really hard to cope.”

She described how some of the strategies she learnt from Fostering Changes did not work during this time due to the severity of her child’s behaviours. Moreover, she mentioned that there was no-one offering support in terms of advising her on what support services were available that would have been beneficial for her child e.g. counselling.

“...so umm, I guess it’s, it’s how do you manage when you’re in a really crisis situation?”

(c) Continuation of the child’s difficulties. All five carers spoke of aspects of their child’s difficulties which had been ongoing in the 13-15 month period following training. This included different types of behavioural difficulties, and the child’s feelings of insecurity.

(i) Continuation of the child’s felt insecurity within the placement. Four carers spoke of how their child currently, at times, still expresses uncertainty regarding the permanency of their placement and fears that at some point they will be forced to leave.

One carer described that when their child feels that he has done something wrong (e.g. misbehaved), then he becomes fearful that he will need to leave their home.

“...he needs to know that...he’s never going to leave our home because that’s a big fear that he has, even now after seven years.”

Another carer described how her child’s level of insecurity has slowly decreased over time which she attributes to the longevity of the placement. Despite this she explained that her child still shows, at times, these signs of feeling insecure.

“...now and again she will say, you don’t need to love me. You don’t need to be caring for me. You’ve got a boy. You’ve got [biological child’s name] and umm, he is your child and I’m not your child...”

Two carers described how they believed that at times their child’s difficult behaviours were linked to their child’s felt insecurity. One carer explained that, at times, her child feels unsure about the future of the placement and as a result will become more defiant and misbehave.

“[He] starts to act out and I think he really feels unsafe...like they’re going to kick me out of the house.”

Similarly, another carer described how she believed that a lot of her child’s challenging behaviours were due to her uncertainty around whether she would be staying with them long term or would be returning to the care of her biological mother. She explained that approximately six months post training, when the decision was made that their child would not be returning to their mother’s care, she saw a major shift in her behaviour.

“We started explaining to [her] what the situation was and that we’re going to court and we’re doing this and we’re doing that, um (pause) her behaviour changed, we weren’t getting the, the naughty behaviour, the-the really disrespectful behaviour.”

(ii) Ongoing behavioural difficulties. All carers described aspects of their child’s difficult behaviours which were ongoing or remained largely unchanged since completing the Fostering Changes programme. One carer explained that after Fostering Changes her child had *“ongoing behavioural problems”* which led her to seek further professional support. She also described a period during which her child’s behaviours became more severe and were very difficult to manage. Similarly, another carer also described how since completing the programme they have had ongoing issues with their child constantly seeking her attention but ignoring their partner. She stated that it has *“always been this way”* but that the intensity of it has increased to a point where they are now trying to find ways of resolving it.

“...because I think after all this time that he’s been in our home, it’s probably, yeah, it’s time to reduce that so he doesn’t need ahh, my attention every 30 seconds, or yeah, once in a few minutes....so that’s what we’re now working on.”

Throughout one carer’s account, the focus was on changes within herself and her caregiving skills rather than changes to her child’s behaviour or functioning. Further, she

described how her child's "clingy" behaviour has remained unchanged and will likely be ongoing.

"...she still is and I think she always will be."

She described that what *has* changed is her level of understanding of what triggers the behaviour, and how to respond to it in a more constructive way without getting angry.

Another carer explained that her child's behaviour has been "*much the same*" since completing the Fostering Changes training. Although she has noticed some reduction in her child's anxiety, this has still been an ongoing difficulty which she is currently seeking professional support for. In fact, she explains that she thinks this anxiety "*will be an ongoing challenge for [her child]*". She does not attribute this small change to any improvements in her caregiving as a result of the course, but rather that:

"She's maturing. She's just, you know, she's getting older. Ummm, and she's, she's always I think, in her own way, trying to make her life okay."

One carer explained that while there were strategies from the programme that helped her to manage some aspects of her child's behaviour that were more predictable, her child's behaviour was often unpredictable and "*erratic*", and therefore continued to be difficult to manage. She described that this type of behaviour can sometimes be in response to a trauma reminder.

"I mean if you were walking in the supermarket, and he'd just lie down on the floor and start screaming, um you'd think, oh where did that come from...it could just be that he'd noticed something out of the corner of his eye that brought back something."

(d) High stress levels remained. Four carers discussed how they still experienced high levels of stress after completing the Fostering Changes programme. Two of these carers spoke of their high levels of stress related to caregiving overall, while the other two carers spoke of a specific aspect of caregiving which continued to cause them stress.

One carer described how their stress levels over the last 13-15 months have fluctuated due their child having "*ups and downs*".

"I mean he feels good, yeah, everything goes pretty easy, and when he's not feeling good, then it takes up a whole lot of our, of our energy."

While this carer noted that periods of heightened stress had comparatively reduced since completing the Fostering Changes training, they explained that overall their stress levels have

still been very high. She believes this is because of the demanding nature of their caregiving role, which takes up a lot of her and her partner's time and energy, making it difficult to pursue interests they previously enjoyed.

"Umm, the fact that it's really hard to umm, to relax and actually ahh, regain umm, energy. And so he needs a lot of time and attention and so before we had much more of a social life, before [child's name] and we did a lot of sports and, yeah, like the holidays and all that kind of stuff. So that's now much more, umm in the background, so and yeah, we struggle to, at times to actually find the energy even to, yeah, call up friends and do something..."

"...we've done a lot of tramping and multi-day mountain bike ahh trips and all that kind of stuff so what we also got our energy from. So that's no longer possible."

Further, she explained that when they do find time to pursue their interests, such as going away backpacking, they are unable to use these opportunities to relax and revitalise because of their child's difficult behaviours.

"So a lot of them now, if we go on a holiday, that we get energy from, it's much more over drained, yeah, because he gets totally upset and his behaviour goes out of control."

Another carer described how her stress levels after the Fostering Changes training programme were *"probably about the same"* in comparison to before she completed the programme. She spoke of how caregiving has been stressful over the last 13-15 months but was particularly stressful during a period when her child's behaviours became very severe and he was excluded from school.

"...it was extra stressful then and umm, I guess my health does suffer because of that umm, but it, yeah, and it's really hard because umm, even though we get respite care days, there's no one to look after him."

She believes that what contributes to this level of stress is being unable to find someone who will provide respite care due to the severity of her child's behaviours.

"So it's trying to find somebody that will actually have him so that we can have a break."

A different carer described her stress as being multifactorial and therefore while some aspects of her stress related to caregiving had reduced, due to the positive impacts of the

course, other aspects of her stress remained. She explained that her stress in relation to being unable to access services her child needed, continued after the programme.

“...there was a lot of stress for us knowing that we weren’t doing the best for [child’s name], um no matter how much we tried we weren’t able to give him the care, the um, yea um the counselling, the occupational therapy, all those speech therapy...”

“Yeah, yeah cos I mean we weren’t, I mean the course wasn’t about getting us the help, and so that was still a really big issue, well it was the biggest issue that we had, knowing that he needed specialised help and we couldn’t access it.”

This carer discussed how she thought that although they were not able to access a lot of services due to issues within the system, it still would have been helpful to know what services were available in their community, in particular during times when they needed to advocate for their child. She recommended that the Fostering Changes programme provide their participants with information on the different services that exist.

“Something that I thought the course could have provided was, um I mean, people would say oh well we went to [name of service] and that helped this or we went to here and this and that, I mean I don’t know if they could have provided a list of resources. But um, I mean, again it’s not strictly part of the course, but it would have been definitely helpful to have all those services, and I mean we weren’t in a position to be able to financially do all that, um, but at least you’d know, like when we went to some of these meetings we could have asked for some of these things, that we didn’t know were available. That was a big frustration that I had, that we’d get to the FGC and we were meant to write all these recommendations of what we wanted, well we don’t know what we want, because we don’t know what’s out there.”

One carer described how she continued to experience stress in regards to the relationship between her child and her child’s biological mother. She explained that her child longs to be back with her biological mother, but the mother is not making the changes needed for her daughter to return to her care. It causes her to feel “*stressed and disturbed*” when the mother misleads her child and provides her with false hope that she can soon return home.

“...and so [child’s name] is living in hope all of the time that Mum’s going to get the lawyer and that she’s going to follow through on more than the bed being made up.”

“...knowing [child’s name] loves and wants mum to umm, step up ,and knowing that mum keeps letting her down.”

Further, it brings her a lot of pain and stress to see her child experience an emotional dilemma between her and her biological mother:

“...when she cries at night sometimes and says about how much she longs that Mum would do and be there for her and then she says, you know, sometime she says I feel guilty because I think I love you more than I love my Mum...I wish I’d come out of your tummy but I shouldn’t say that because my Mum, she’s, you know, she’s got the bed all ready for me and ohh goh and you think, ohh you, it’s not right.”

(e) Negative impacts of placement breakdown on family wellbeing. One carer, who had experienced a placement breakdown after the Fostering Changes programme, described some of the negative impacts this had on her and the family. Placement breakdown is a very common experience in foster care. Therefore, the negative impacts it can have on a family is very much still related to the burden of fostering, albeit in a slightly different way.

Although it was this carer’s decision to end the placement, it nevertheless had many negative impacts on the wellbeing of her family. She believes that *“the impact was actually huge”*. She described how the family grieved for their loss, and that her other two children still miss him very much.

“[she] knew no different than to have [child’s name] in the house, and so she’d wake up in the middle of the night, she still wakes up in the middle of the night, saying she misses [child’s name].”

“...there was almost a grieving process of [child’s name] leaving.”

She also spoke of the negative impact it had on their foster child, who had great difficulty dealing with the separation. For example, she described how after the placement ended he would show very clingy behaviour towards her biological son at school.

“[child’s name] would see [him] at school and wouldn’t know what to do, so he would just hug [him] and not let him go, so [he] had to drag him around at lunchtime cos [child’s name] wouldn’t let go of [him] at school.”

Moreover, she described how she often feels guilty about the placement ending, and frustrated with CYF that his current placement is not providing him with the care that he needs. Despite trying to remind herself that she did what she could, she still feels this sense of guilt.

“...I still think that we have let [child’s name] down.”

“...you could tell it wasn’t the right place for him, and so there was frustration with knowing that you’d put him in a situation that wasn’t good.”

She mentioned that she did not learn anything on the Fostering Changes training programme that helped her work through and cope with this placement breakdown, but that she did not expect this of the programme.

“Well, I mean, I guess the Fostering Changes was about trying to keep placement going, not when they fell apart how things were going to go.”

Theme 4: Variability in carers’ level of confidence.

This theme describes the carers’ confidence in their caregiving ability. While majority of carers described improvements in their levels of confidence after the programme, there were times throughout the 13-15 month period when this decreased or fluctuated.

One carer spoke of how initially after the Fostering Changes programme, she had a greater level of confidence in her caregiving ability. She explained that she felt more confident in being able to manage their child’s difficult behaviours because she had a greater understanding of what was causing them. Further, she stated that after the programme she felt “*more empowered*”. This suggests that she felt stronger and more capable as a carer. However, when describing how she felt currently regarding her level of confidence in being able to understand and manage her child’s behaviours, she stated that:

“Yeah I, feel that we’ve probably just got enough skills to get by.”

This statement compared to those described above, reflects a lower level of confidence in her caregiving ability. It suggests that currently she believes her and her partner only have a minimum set of skills enabling them to cope; they are only just doing well enough.

Another carer also discussed how initially after completing the Fostering Changes programme she felt more confident in herself as a carer. She attributed this to the new strategies she learnt and hearing that other carers were experiencing difficulties as well.

“I definitely, I think had more confidence.”

She explained however, that her belief in her ability to manage and cope has fluctuated somewhat over the last 13-15 months.

“I think umm, you just have ups and downs, I think. And sometimes you can feel really good and sometimes you can feel like you’re going along fine and other times you think, ohh, yeah.”

“...just not knowing what to do at some times.”

When describing how she felt currently in terms of her level of confidence in her caregiving ability, she stated that she would now like to attend a “recap” with the Fostering Changes group. This suggests that perhaps her confidence has decreased over time.

Similarly, another carer also described how her confidence increased after the programme but that over time there would be periods where her level of self-efficacy would lessen as she began to doubt her caregiving abilities. She explained that it has been helpful during these times to look back over the course folder (i.e. course notes), to gain reassurance that she is on the right track, or remind herself of strategies she had forgotten.

“I guess you always start to doubt yourself again...some situations we got through and moved on, but then yeah these new situations again and you’re sort of doubting yourself, well am I doing this the right way, which is why I’ve kept the folder.”

One carer stated that she has always felt confident in her skills in terms of being able to provide the basic caregiving requirements such as a loving and secure environment. However, she described that meeting her child’s specific needs is an ongoing challenge. Feeling confident her ability to meet these specific needs is based upon her receiving further specialised support.

“So we’ve never doubted umm, our ability to parent and care well for a child but it’s the fine tuning of responding particularly to this child, and umm, doing the best by her. Umm, that has been, is the challenge really.”

Another carer described how after completing the Fostering Changes programme her confidence in her caregiving ability increased. She had greater confidence in knowing what was best for her child and how to manage her behaviour and this meant that she began giving advice to the child’s biological mother during contact visits regarding her parenting. When explaining how she feels currently, she stated:

“I feel really confident as a carer.”

This carer however, experienced a period of significant difficulty approximately six months after the programme, in part due to a lack of family support, and came very close to giving up

her role as a carer. At the time she felt that she could no longer cope. She described that she *“felt like a complete failure”*. During this time she had a low level of confidence in herself as a carer; she did not have the belief in herself to continue successfully as a carer in the context of this adversity.

Theme 5: Training for carers is important.

When discussing their perspectives on training for carers in general, all five carers discussed how they believed that it should be compulsory, as evidenced in the example statements below:

“I think it should be something that all carers do.”

“I think it’s totally necessary that it happens...”

“...because it’s a huge commitment you make, and if you really want to do it well, I think training is important.”

One carer expressed how important she believed training to be in helping carers to understand why their child is behaving in certain ways.

“So you can’t um, you can’t take these kids into your home if you don’t understand why they are misbehaving.”

This same carer stated that while CYF provided a satisfactory introductory course to fostering, she recommends that those carers with little experience should attend further training from a programme such as Fostering Changes.

“...CYFs actually does quite a good job of getting you, giving an introduction to the issues of foster kids but ahh, I think...probably for foster parents, if they don’t have extensive um experience, it’s really good to do something like the course like ah Fostering Changes ahh course.”

Another carer expressed the value in attending training while you have the child in your care, but that it is important to also attend training before you begin caregiving so that you are more aware of what to expect.

“I think that um this Fostering Changes [is] a great course to have once you’ve got the child, but you need something before that...so that you’re more aware of what, what you’re in for really.”

Two carers discussed how they believed that ideally carers should receive ongoing training. Both carers however, identified that it can be hard for carers to find the time. One of these carers suggested that “*online training*” could be provided for carers who have limited time or money to attend training groups such as Fostering Changes. Further, she suggested having a mentor that you could talk to online.

“I think umm, having some sort of a mentor maybe online could be really an ongoing weekly thing. Umm, but in terms of when you’re going in and doing something like that, maybe yearly.”

Another carer explained how she thought training is very important for all carers to undergo, however those carers who are beneficiaries and therefore more likely to struggle with caregiving, are in fact those least likely to be able to attend training given their more difficult circumstances.

“And seeing it, you know, this latest Paula Webstock report, saying that 46 percent of our caregivers are beneficiaries. You know, that’s hugely challenging. People will be, their own lives will be, you know impoverished in many ways because they’re living on the benefit. And then they take in some impoverished kid...[for many] it’ll be a struggle.”

Chapter 5: Discussion

The purpose of the present study was to explore foster carers' perceptions and experiences of the effects of participating in the Fostering Changes programme in the 13-15 month period following training. There were two study aims. The first was to investigate what effects from Fostering Changes, if any, the participants experienced over the last 13-15 months, and how they perceived such effects or non-effects to have unfolded over this time period. The second aim was to explore carers' perceptions regarding any effects the programme had currently on their fostering experiences.

The research question and study aims were addressed using semi-structured interviews with carers from one group who had completed the Fostering Changes training programme through an organisation in the Canterbury region of New Zealand. Interpretive Phenomenological Analysis (IPA) informed both the data collection and analysis. Five themes emerged which reflected the experiences and perceptions of the carers in this study: Fostering Changes was a beneficial training programme; The need for further professional support post-training; The challenges of fostering continue; Variability in carers' confidence; Training for carers is important.

Summary of the results

Carers in this study spoke highly of the Fostering Changes programme and described it as being a valuable experience. They commented on the usefulness of both the content of the programme as well as the group format. Carers discussed a range of positive changes to their caregiving competencies as a result of Fostering Changes which they had implemented since completing the training. These contributed to positive outcomes for themselves, their child and their family members. Carers also discussed the importance of training in general and that it should be compulsory. Despite the positive impacts of the Fostering Changes programme, carers described the ongoing challenges of fostering and the need for further professional support. Further, while the majority of carers experienced increases in their confidence initially following training, there were times throughout the 13-15 month period following training when this decreased or fluctuated.

This chapter will provide a discussion of the study findings and how these relate to the literature. Following this, there will be a section on the strengths and limitations of the study, recommendations for the Fostering Changes programme, implications, and future research. The chapter will end with key take home messages.

Theme 1: Fostering Changes was a beneficial training programme

An important finding from the current study was that all carers' provided very positive feedback about the Fostering Changes training programme and the impacts that it had on their fostering experiences. In fact, none of the carers provided any negative comments or discussed the programme as being detrimental in any way. This finding suggests that Fostering Changes is a well-designed training programme that is highly valued by carers who attend. All carers expressed high levels of satisfaction with the programme's content, of which two rated it as being more useful than other trainings they had attended prior. They also discussed the benefits of the programme being delivered within a group format. This included gaining reassurance from knowing they were not the only ones experiencing difficulties, and the sharing between carers of knowledge and strategies gained from personal experience. For one carer, participating in the group had a positive impact on her personal attributes. It helped to improve her interpersonal skills and confidence engaging with unfamiliar people. She explained that she therefore would not have been able to participate in the interview if she had not attended the programme.

Congruent with the findings from this current study, post-training evaluations of other programmes outlined in the literature review, as well as the evaluations of the Fostering Changes programme, have also found that carers have provided very positive feedback and reported high levels of satisfaction with the training they have received. Through administration of a satisfaction questionnaire, many studies have provided quantitative evidence that carers rate the aspects of training and its impact highly, and overall are satisfied or very satisfied with the group training (Golding & Picken, 2004; Gurney-Smith et al., 2010; Herbert & Wookey, 2007; Hill-Tout et al., 2003; Holmes & Silver, 2010; Macdonald & Turner, 2005; Minnis et al., 2001; Nilsen, 2007; Pallett et al., 2002). There is also qualitative evidence, in the form of answers to open-ended questions in a satisfaction questionnaire, interviews, and group discussions, that carers express positive views about the training and perceive it to be beneficial (Allen & Vostanis, 2005; Golding & Picken, 2004; Gurney-Smith et al., 2010; Holmes & Silver, 2010; Laybourne et al., 2008; Pallett et al., 2002; Warman et al., 2006). The satisfaction ratings and reports from carers in these other studies were taken more or less directly following training. The fact that carers in the current study still spoke very highly of the Fostering Changes programme after more than a year had passed since they attended, is a very significant finding. This is connected with the study finding that

carers have continued to benefit from the impacts of Fostering Changes over the 13-15 month period following training.

Also consistent with the findings of the current study, qualitative evidence from several other evaluations of training programmes, have found that carers value the group format of training. Reported benefits have included being able to share experiences with, and learn from, other carers who are facing similar issues, and feeling supported (Golding & Picken, 2004; Gurney-Smith et al., 2010; Holmes & Silver, 2010; Laybourne et al., 2008; Nilsen, 2007). Pallett et al. (2002) and Warman et al. (2006) describe the group format as an important aspect of the Fostering Changes programme which carers value just as much as the training content. According to Pallett et al. (2002), it provides carers with the opportunity to hear from others in a similar position to themselves which in turn can provide relief and a sense of empowerment. Further, the experiences carers share are considered to be a valued source of knowledge which can contribute to the group's learning (Pallett et al., 2002). This is reflective of carers' accounts in the current study.

The Fostering Changes programme appears to have had an enduring impact on the carers in this study. Carers spoke of the positive changes to their caregiving competencies as a result of the training, which they continue to apply currently. These included having a greater insight into their child's behaviour, increased emphasis on attending to positive behaviours and using praise, improved regulation of emotional reactions, and increased patience and acceptance. The Fostering Changes programme is still having an impact on their caregiving even after a year following training. This is a significant finding which has not been identified in the literature.

Evaluations of other training programmes which have provided qualitative evidence of improved carer-related outcomes, have found results which are similar to those in the current study. In the 'one-off' studies by Allen and Vostanis (2005) and Holmes and Silver (2010), which evaluated training programmes that were based on or incorporated Attachment Theory, carers reported that following training they had a greater understanding of their child's difficulties. This meant that they developed more realistic expectations for what their child could achieve (Allen & Vostanis, 2005), and responded to their child's behaviour with a calmer and more empathetic approach (Holmes & Silver, 2010). Similar to these findings, two carers in the current study reported how through an increased understanding of their child they became more accepting and tolerant of their child's difficult behaviours, with one of these carers also explaining how she subsequently altered her expectations and became more patient. Evaluations of the Fostering Attachments training programme have also found

evidence (both quantitative and qualitative) of carers' improved understanding of their child following training (Golding & Picken, 2004; Gurney-Smith et al., 2010; Laybourne et al., 2008). Similar to the above findings, in the study by Laybourne et al. (2008) carers reported that due to an increased understanding of attachment they began to respond to their child with more empathy.

Several studies have found quantitative evidence of improved caregiving competencies following training including knowledge of behavioural principles (Herbert & Wookey, 2007; Macdonald & Turner, 2005). In contrast to this, a few studies have not found any significant quantitative changes in carer-related outcomes including caregiving knowledge, attitudes, and understanding of child behaviour (Hill-Tout et al., 2003; Nilsen, 2007). It is not appropriate however, to draw comparisons between these *quantitative* results and the *qualitative* findings from the current study. Moreover, there is limited evidence in the existing evaluations of the Fostering Changes programme, on how training impacts on specific caregiving skills. An exception to this is a quantitative measure used in the RCT. However, this only reveals pre-post changes in mean total scores of the group (Briskman et al., 2012).

Carers did not express disappointment in the Fostering Changes programme given the continuation of their child's difficulties or the challenges in caregiving that they continued to experience post training, as outlined in theme two and three. This suggests that carers had realistic expectations of what the programme could achieve; that it does not provide a one-step approach to helping carers or a solution to their children's difficulties. This is likely to be associated with carers' reports of increases in understanding around their child's functioning and development, including the impacts of trauma, as well as greater levels of patience and acceptance of their child's difficulties.

All carers discussed the positive impacts their improved caregiving skills had on themselves, their child and/or other family members. This included improvements in the carer-child relationship, placement stability, the transferring of skills to other family members, improvements in some of their child's behaviour, and reduced stress. Carers have continued to benefit from the programme over time, with some carers providing current examples of these positive impacts.

One carer explained that as a result of her increased level of patience, and greater acceptance of her child's difficulties, her relationship with her child became more harmonious. She described how their interactions together are now more positive and enjoyable. Further, one carer explained how her increased level of patience and use of

positive reinforcement led to improvements overtime in aspects of the child-carer relationship. Evaluations of the Fostering Attachments programme have used a variety of quantitative measures to assess changes in the child-carer relationship, specifically the attachment relationship. Findings have revealed a lack of significant measureable improvements in this outcome variable (Gurney-Smith et al., 2010; Laybourne et al., 2008; Wassall, 2011). On the other hand, the RCT of the Fostering Changes programme did find significant improvements in the attachment relationship between carer and child, although using a different quantitative measure (Briskman et al., 2012). There is limited qualitative evidence regarding changes to the child-carer relationship, making it difficult to compare the current findings to the literature. Further, it is not possible, or appropriate to, determine whether the carers' accounts in this study are reflective of changes to the attachment relationship.

One carer described how the skills and understanding acquired through the training contributed to the stability of the care placement, and that if they had not attended the programme it is possible that they may have given up fostering. Given that this is the ultimate goal of carer training programmes, this is a very significant finding. It is important to note however, that carers do not have the same priorities and needs. As outlined in theme three, one carer experienced a placement breakdown and another came close to giving up their fostering role following training.

Two carers described how they had transferred the skills and knowledge that they gained from the programme to other family members. One of the carers described how as a result of her improved emotional regulation and communication skills, talking with her husband about her feelings is now a lot easier. Another carer explained how due to her increased understanding around child development, and impacts of neglect, she has recently begun to spend more time with her other child to give her the experiences she needs to develop optimally. It appears that this finding has not been identified in the current literature on group training programmes.

Two carers spoke of how their continued use of the strategies and skills they had learnt, for example positive reinforcement, led to improvements in some of their child's behaviour. As one of the carers stated, this then had a positive impact on her family. Further, carers also discussed how changes in their caregiving, including having a greater understanding of their child, meant that they experienced reduced stress levels. As outlined in theme three however, all carers spoke of aspects of their child's behavioural difficulties which were ongoing or remained largely unchanged, and majority discussed how they still

experienced high stress levels following training. This highlights the complexity and variability in these carers' experiences.

Theme 2: The need for further professional support post training

Carers discussed their use of other forms of professional support post training due to some of their child's very challenging behaviours. This is connected to the sub-theme of theme three, which describes carers' reports of their children's on-going difficulties. The carers indicated that their caregiving competencies were not sufficient to deal with these behaviours. Carers did not just attend further carer training similar to Fostering Changes. Rather, they sought support services which worked directly with their child or with the child and carer together. These included: Multi-Systemic Therapy, mental health services (for child assessments), Intensive Case Management, and a play therapist. One carer also attended a more specialised training programme specific to providing care for teenagers. To the author's knowledge, this finding has not been identified in other evaluations of group training programmes. There appears to be a lack of research investigating the level of ongoing support carers need following single, time-limited, group training programmes.

Carers' involvement with other forms of professional support post training was not discussed as a shortcoming of the Fostering Changes programme. The carers felt that the programme was very beneficial and they still spoke very positively about it. If the carers had attended further carer training, which provided a similar curriculum and format to that of Fostering Changes, then this would potentially point to a limitation of the programme. However, this was not the case. What this outcome is more reflective of is the complexity and severity of these children's difficulties, which is highlighted frequently throughout the literature (Howe, 2009; Tarren-Sweeney, 2008a; Tarren-Sweeney & Hazell, 2006). Despite improved caregiving competencies as a result of the programme, these children required ongoing specialised support.

Given the challenging nature of foster carers' role and the severity of these children's difficulties, it would seem unlikely that one time-limited carer training programme would be able to provide carers with all the skills and knowledge needed for them to continue fostering without any further support. The findings from this study support this. One carer explained that Fostering Changes is not sufficient on its own but that it has been an important contribution to the range of support she has received during her time as a carer. She discussed that although the programme was helpful, carer training on its own is not enough to bring

about positive changes to difficult child behaviours, and that appropriate support in other settings such as the school, needs to be considered. This is consistent with the suggestions made by Hill-Tout et al. (2003). They believed that in order for change in child behaviour to occur, changes at a system level are needed. For example, they recommended that teachers and social workers also participate in training alongside carers so that a consistent approach to challenging child behaviour is applied across settings (Hill-Tout et al., 2003). Further, they discussed how carer training should be provided as an important component of a wider support system (Pithouse et al., 2002).

Three carers in this study spoke of how continued support from Fostering Changes itself would have been helpful. This finding indicates that these carers perceived the programme to be a helpful source of knowledge and skills which they could continue to benefit from. One type of support identified by carers was a follow-up session/s, which would help to refresh their memory of strategies potentially forgotten, and/or provide support for new and on-going challenges. There appears to be only two other training evaluations identified in the literature review that have reported on carers' desire for follow-up. In the study by Allen and Vostanis (2005), an evaluation of Attachment-based training programme, carers discussed how they wanted further support post-training in the form of regular follow-up sessions, to help with any difficulties they experienced in trying to apply the strategies that were taught. Further, in the evaluation of a different training programme, conducted by Holmes and Silver (2010), carers suggested that a follow-up session six months post training would be helpful.

Two carers in the current study discussed how attending a follow-up session/s would be helpful as it could provide them with support for issues which were not present or prominent at the time of training. This finding highlights the ongoing challenges that these carers experienced as outlined in theme three of the results. This finding could suggest that these carers were unable to transfer the skills they had learnt to new issues they experienced after the programme. Although training sessions followed a manualised programme, given the format and collaborative approach it is likely that the facilitators employed group discussions around specific examples of issues participants raised. More investigation around this potential explanation is needed. It is also important to consider that carers experience a range of ongoing, complex issues and that it is unlikely the skills taught in the programme are able to apply to all of these.

Two carers expressed the desire for additional support from the group directly following training, but which was in a different format: a Facebook page; a one-on-one

session with the facilitators. Although all five carers spoke of the benefits of the group format, one carer described that a limitation of being with a group of carers, in the context of time-limited sessions, was that she felt unable to discuss her personal circumstances in enough detail. She discussed how she therefore would have benefited from some one-on-one time with the facilitators post training.

All carers expressed a desire to receive further professional support in the future (i.e. beyond the 13-15 months post training). Two carers strongly believed that they could never have enough training and could always improve their caregiving skills. Further, three carers discussed how they would like to seek further support or training at some point in the future that targeted specific issues such as child anxiety, issues around birth parents, and caring for adolescents. This finding suggests that these carers want to further improve their caregiving skills so that they are able to provide the best care that they can. They believe that they require further professional support in order to be as competent as they can in meeting their child's specific needs.

The findings from this theme suggest the following: 1. carers require on-going professional support, 2. carers require diverse forms of supports, and 3. these children require specialised support given the severity and complexity of their difficulties.

Theme 3: The challenges of fostering continue

An important finding from this study was that although the Fostering Changes programme led to improvements in caregiving competencies and subsequent positive impacts on the carer, child and family, carers continued to experience significant challenges related to fostering over the 13-15 month period following training. This finding highlights the complex and difficult nature of carers' role as described frequently throughout the literature (Farmer et al., 2004; McDonald, 2011; Nutt, 2006; Sinclair et al., 2004), and is connected with carers' need for further support post training.

One carer explained that although the Fostering Changes training was very helpful and improved their caregiving competencies, fostering has continued to be an ongoing daily struggle, and they are only just managing to get by. Further, three carers discussed how they experienced a point of crisis in the 13-15 month period following training. All three discussed how a lack of support contributed towards this period of significant difficulty. One carer described how they were unable to access the support their child needed due to issues within the care system, which subsequently contributed to the placement breaking down. Another

carer explained how family conflict, as a result of her caregiving role, and a lack of support from her husband, meant that she came very close to giving up her role as carer. These carers' accounts suggest that the quality of other forms of support is important in maintaining the care placement. This does not reflect negatively on the effectiveness of the Fostering Changes programme. Rather, it indicates that there are challenges to a carers' role which cannot be addressed by carer training alone. As outlined in the literature there are other types of support aside from training, both informal (e.g. family) and formal (e.g. other professional services), that carers report as being important in facilitating their fostering role (Farmer et al., 2004; Murray et al., 2011; Sinclair et al., 2004).

All carers discussed how aspects of their child's difficulties had been ongoing or remained largely unchanged since the training, with two carers describing how the severity of some of their child's behaviour increased during a period. These findings provide further evidence that developmental recovery for these children occurs over a long period (Tarren-Sweeney, 2014). For this reason it has been argued throughout the literature that studies need to employ longer pre-post evaluation timeframes when investigating the effectiveness of carer training programmes (Laybourne et al., 2008; Rork & McNeil, 2011; Tarren-Sweeney, 2014; Turner et al., 2009; Wassall, 2011). This study reveals that even after a year following carer training, some of these children's difficulties may remain unchanged. Perhaps training evaluations should focus less on assessing reductions in child behavioural problems and more on carer-related outcomes.

A substantial number of studies outlined in the literature review have reported a lack of significant measurable change in child behaviour problems following carer training (Hill-Tout et al., 2003; Laybourne et al., 2008; Macdonald & Turner, 2005; Minnis et al., 2001; Wassall, 2011). In response to these findings, it has been suggested that carer training is potentially not sufficient on its own to bring about changes in child behaviour given the severity of these children's difficulties (Hill-Tout et al., 2003; Macdonald & Turner, 2005). This appears to be congruent with this study's finding, which revealed that majority of carers sought other forms of professional support following Fostering Changes due to their child's ongoing difficulties. There are however, several studies which have found significant measurable improvements in child difficulties including the evaluations of KEEP (Chamberlain, Price, Leve, et al., 2008; Price et al., 2015) and Fostering Changes (Briskman et al., 2012; Pallett et al., 2002; Warman et al., 2006). It is not clear from the literature why there are variations in these child-related outcomes across different training programmes.

Further research is needed to investigate whether this is related to the training itself, the measures used, or other variables.

Four carers discussed how their child currently, at times, still expresses feelings of insecurity regarding the permanency of the placement. One carer described that this is still the case even after being in their care for 7 years. The study findings do not reveal the extent to which this has changed since carers completed training, only that this is still a current issue for these children. Two carers described how they believed that their child's difficult behaviours were linked to this felt insecurity. In fact, one of these carers described how there was a significant improvement in her child's behaviour approximately six months post training, when they informed their child that the placement would become permanent. This finding is congruent with the current thinking around the importance of long-term, stable placements for these children. Research has shown that being raised in impermanent care is detrimental to a child's mental health (Delfabbro & Barber, 2003; Newton et al., 2000; Tarren-Sweeney, 2008b). Ensuring that these children are in a stable caregiving environment with committed carers over several years is vital for their developmental recovery (Tarren-Sweeney, 2014). It is important that care policies support placement permanency. Even if a carer has proficient caregiving skills, there may be systemic reasons for why a child feels insecure, and which carer training is unable to address.

The majority of carers discussed how they still experienced high levels of stress in the 13-15 month period following training. For some carers their stress reduced in one specific area of caregiving but remained elevated in another. As one carer explained, stress is multifactorial. This carer described that being unable to access the specialised services her child needed, continued to cause her a great deal of stress after the programme. Further, another carer discussed how she continued to experience a great deal of emotional pain and stress following training, which was associated with the issues in the relationship between her child and her child's biological mother. Studies evaluating training programmes commonly measure changes in carers' stress quantitatively using the Parental Stress Index. A major limitation of using this measure is that it is designed for birth parents, and does not include those stresses specific to foster carers such as the ones described above (Abidin, 1995). A more appropriate measure needs to be developed that taps into the types of stress that carers experience.

One carer explained that although her stress levels had comparatively reduced since completing the training, they had still been very high. She attributed this to caregiving being very time consuming and draining, and the difficulty in finding opportunities to regain energy

due to their child's challenging behaviours. Another carer mentioned that her stress levels had remained largely unchanged since completing the programme. She had continued to experience high stress related to caregiving, which were particularly elevated during a time when her child's behaviour became very severe. She described this as being detrimental to her health. The stress associated with managing a child's severe emotional and behavioural difficulties is commonly reported by carers in the literature (Buehler et al., 2003; Jones & Morrisette, 1999; Morgan & Baron, 2011; Murray et al., 2011). It is important that carers receive the ongoing support they need to help manage and reduce these levels of stress, as research has shown that it can be detrimental to the quality of care that is provided and can contribute towards placement breakdown (Farmer et al., 2004; Sinclair et al., 2004). Both of these carers discussed the importance of finding the time to pursue their interests and have a break. Consistent with this finding, respite care has been identified by carers in the literature as an important source of support that is needed to ensure the wellbeing of themselves and their family (MacGregor et al., 2006; Wells, 2004).

One carer who experienced a placement breakdown post-training, described the negative impacts this had on the wellbeing of herself, her family, and the child who left their care. The emotional impacts a placement breakdown has on foster carers and their family, is commonly reported in the literature (Nutt, 2006; Sinclair et al., 2004; Younes & Harp, 2007). Although carer training programmes have the ultimate goal of ensuring placement stability, this desired outcome is not always achieved and it is important for families to receive the support they need to help them through this difficult time.

Theme 4: Variability in carers' level of confidence

A common aim of carer training programmes, including Fostering Changes, is to improve carers' confidence in their caregiving abilities (Allen & Vostanis, 2005; Briskman et al., 2012; Golding & Picken, 2004; Herbert & Wookey, 2007; Macdonald & Turner, 2005; Wassall, 2011). Improvements in this carer-related outcome have been identified in the qualitative accounts of carers across several different training evaluations in the literature (Allen & Vostanis, 2005; Golding & Picken, 2004; Macdonald & Turner, 2005). Increases in carers' confidence using quantitative measures have also been found (Golding & Picken, 2004; Herbert & Wookey, 2007; Holmes & Silver, 2010; Wassall, 2011). Moreover, evaluations of the Fostering Changes programme have found both quantitative and qualitative evidence that carers' confidence increases following training (Briskman et al., 2012; Pallett et

al., 2002; Warman et al., 2006). There is however, a lack of knowledge in the literature around how carers' confidence varies over time following training.

Consistent with findings from other studies, majority of carers in the current study described how their confidence in their caregiving abilities increased initially after completing the Fostering Changes programme. Reasons for this increase included having an increased understanding of their child, learning new strategies, and knowing that other carers were also experiencing difficulties. However, there were times throughout the 13-15 month period following training where carers' confidence decreased or fluctuated. This finding has not been identified in other evaluations of training programmes in the literature. The accounts from some of the carers indicated that decreases in their confidence were associated with a lack of family support, and periods of self-doubt. Further, one carer described feeling confident in her basic caregiving skills but less so in her ability to meet her child's specific needs and that she required further specialised support.

Theme 5: Training for carers is important

All carers in the study discussed how they believed that training should be compulsory for foster carers. This is a significant finding and is likely to be associated with carers' positive experiences participating in the Fostering Changes programme. Despite their ongoing challenges and need for other forms of professional support, the carers perceived training to be necessary. Congruent with this finding, carers across several different studies have identified training to be an important source of support (Hudson & Levasseur, 2002; Murray et al., 2011; Octoman & McLean, 2014; Sinclair et al., 2004). Further, two carers in the study believed that ideally carers should receive ongoing training but that time and money can be potential barriers to attendance. One carer therefore suggested that online training be provided, or an online mentor. Difficulties in being able to access training have been identified by carers in the literature (Department of Child Youth and Family, 2007; Murray et al., 2011; Sinclair et al., 2004). Consistent with this study finding, computer-based training has been recommended by carers across several studies as a way of making training more accessible (Department of Child Youth and Family, 2007; Murray, 2007).

Limitations and Strengths of the study

The small sample size used is a potential limitation of this study. It is difficult to make generalisations from the study's findings to other carers who have undergone training.

However, this sample size adheres to the IPA guidelines (Smith et al., 2009). Further, it allows for a more in-depth analysis of participants' perceptions and experiences. This is helpful for practitioners as it reveals the complexity of what goes on for these carers. This study was explorative and did not set out to make *conclusive* statements about how carers experience and perceive the long-term impacts of training. It has provided valuable information which can be used as a starting point for future research.

Although IPA was identified as being the most appropriate methodology for this research, there were some issues with using this approach. Given the complexity of these carers' experiences, it was at times quite difficult to separate these into individual themes. A lot of information overlapped across themes. For example, carers' need for further professional support post training was very much connected with their experiences of ongoing challenges. Further, while some carers spoke of improvements in their child's behaviour they also spoke of how their child had difficulties which remained unchanged. It was therefore noted to the reader that these themes should not be read in isolation. It seemed unnatural to break up carers' accounts into these distinct categories as they were very much interconnected.

A strength of this study was that the participants were very willing to open up during the interviews and share their experiences. This was indicated by the length of the interviews which on average lasted for at least 90 minutes each. The accounts provided by the participants were personal and detailed. Further, there were no instances where a participant did not want to answer a particular question. All participants were very forthcoming with information. As a result rich qualitative data was collected. This is a key strength of the study. As Smith et al. (2009) explains, "An IPA analysis is only as good as the data it is derived from" (p. 180).

The way the interview schedule was structured and questions were worded was another strength of this study. It meant that the responses elicited were of both breadth and depth. Rather than directly asking participants from the outset what they thought the effects of the training were, they were instead asked to discuss their fostering experiences after completing training. For this reason, important but unanticipated responses were obtained, for example carers' involvement with other professional support services following training.

Several steps were carried out to minimise participant response bias and to reduce any potential negative effects the study might have on participants' relationship with the organisation. This is an important strength of the study. First, the organisation was not commissioning the study nor was it being carried out on their behalf. Second, the

organisation did not have access to the interview transcripts. These were outlined in both the information sheet and consent form. Third, participants knew that their anonymity would be protected. These steps helped to ensure that participants did not feel obligated to respond positively about the programme in order to appear favourable to, and protect their relationship with, the organisation. Fourth, it was made clear to the participants at the start of the interview that the programme may or may not have had effects on their caregiving experiences and that the researcher was interested in both. Further, interview questions were worded carefully as to not assume that the programme had effects on carers' fostering experiences. This helped to ensure that participants did not feel the need to overestimate the extent to which the programme was connected with their fostering experiences in order to appear more favourable to the research.

The thorough analysis of the data, which was carried out over a period of 3-4 months, is another key strength of the current study. As outlined in the method chapter, IPA provides a set of clear steps for data analysis. Supervision was used to check that these steps were being followed correctly. This helped to ensure that the data were being analysed in the same detailed way for each participant. Supervision and a peer debriefing process were also used to help make sense of the interpretations being made and to consider alternatives. Further, throughout the entire process the original transcripts were continually revisited to ensure that the themes were reflective of the raw data. This meant that carers' perspectives and experiences were presented as accurately as possible.

Recommendations for the Fostering Changes Programme

From the study's findings it is difficult to recommend modifications to the programme's curriculum, as all carers provided very positive feedback and did not express any dissatisfaction with the training. Further, all carers spoke about the benefits of the group processes. This indicates that the group format should continue to be the method of delivery for this programme. However, two carers in this study spoke of the benefits of having one-on-one support from trainers. As outlined in the 2nd edition of the manual, facilitators of the Fostering Changes programme carry out individual home visits as part of the recruitment process. It also provides facilitators with the opportunity to get to know the carers and build an initial positive rapport, get an idea of the difficulties they are experiencing, and a clearer picture of their situation at home (Bachmann et al., 2011). Perhaps these home visits could be provided again at a later point or throughout the 12 week programme to address issues that

these carers have not had time to discuss in the group, and to provide more targeted support within the caregiving environment.

Near the end of the 2nd edition manual, there is a section which discusses how carers in the group may express interest in continuing to meet with the group and receiving further support (Bachmann et al., 2011). This is consistent with the findings of the current study. The manual outlines that facilitators may therefore want to consider providing a follow-up, refresher sessions, or additional training after the programme (Bachmann et al., 2011). Perhaps one or more follow-up sessions should be integrated as a formal component of the training programme rather than just being provided as a suggestion. This could potentially provide support for carers experiencing ongoing high levels of stress, and fluctuations in confidence, as found in the current study. However, carers may not have the time or funds (e.g. childcare and travel costs) to attend such follow-ups. An alternative suggestion, which was made by one of the carers in this study, is setting up an online forum such as Facebook, which would enable them to stay connected with the group of carers and possibly the facilitators as well. Through this they could discuss ongoing or new issues they are having and seek advice.

Implications

The study findings indicate that regardless of how well designed and implemented a training programme or intervention is, foster carers still have the need for ongoing psychosocial and clinical support. This is because children in care have complex mental health difficulties that follow a slow recovery trajectory (Tarren-Sweeney, 2014). The developmental impacts of early trauma and impermanent care continue to compromise children's development and wellbeing, regardless of foster caring abilities (Tarren-Sweeney, 2008b). Carers therefore experience ongoing challenges in their caregiving role.

Carers' needs for training, support, and clinical services cannot be solely met through a single, time-limited, group training programme. Although they are very important and highly valued by carers, they are not a panacea. It is important that statutory authorities and other children's agencies do not pour funding into carer training programmes that have a strong evidence base, with the hope that these will provide a solution to carers' difficulties, and subsequently overlook their need for ongoing, diverse forms of support. Rather than being conducted in isolation, statutory authorities and agencies should consider how carer training programmes such as Fostering Changes can be incorporated in coordination with

other support services, i.e. a multi-component support model. It is important that this support can be flexibly responsive to accommodate for fluctuations in foster carers' experiences over time, such as periods of heightened stress and points of crisis. It is also important that they recognise and meet the unique experiences and needs of carers. Further, services should consider how they can stay connected with carers in the long-term rather than providing one-off support. It is important to provide carers with opportunities to continue developing their caregiving skills to maximise their therapeutic potential.

Future research

To the author's knowledge, this type of study appears to be the first of its kind. No other study has evaluated qualitatively how foster carers perceive and experience the effects of participating in a training programme over an extended follow-up period. Further, the follow-up period used in the current study of 13-15 months post training, appears to be the longest that has been conducted for an evaluation of a group training programme for carers. Therefore it would be important that replications of this study were undertaken to help validate and build on these findings. The field would also benefit from more qualitative research on how training programmes impact on carers' behaviours, thoughts, and caregiving competencies. The study findings provide insight into the variability and complexity of carers' experiences of which quantitative research is unable to capture. Moreover, qualitative research is able to provide insight into mechanisms of change, something which is not well understood in this field.

Further research is also needed to explore how the experiences and perceptions regarding the effects of training differ between non-relative and kinship carers. Given that this was a qualitative study of a small sample size, it was not appropriate to draw these comparisons. Exploring these differences is very important as there has been an increasing trend towards finding kinship placements for children in the care system across several different countries (Crosson-Tower, 2007; Hunt, 2009).

An important finding from this study was that carers required or wanted further professional support following training, with majority expressing a desire for continued support from Fostering Changes itself. Therefore, the field would benefit from research that investigated the effects of providing carers with one or more follow-up sessions which provide a 'refresher' of the training, and/or a time for the group to discuss and receive advice for ongoing and new issues. This would help to provide a greater understanding around

carers' need for ongoing support and how carer training programmes might help to accommodate for this. Future research could also explore how carer training programmes might be supported alongside other types of professional services in order to meet the ongoing challenges that carers experiences. Further, it might be useful if studies were to compare the effects of carer training on its own versus training provided within a coordinated support system or package.

Key messages

- Fostering Changes is a well-designed training programme that is highly valued by carers who attend.
- Carers in this study have continued to benefit from the Fostering Changes programme. Participating in the training led to improvements in caregiving competencies and subsequent positive impacts on the carer, child, and family. Nevertheless, carers continued to experience significant challenges related to fostering over the 13-15 month period following training, and required further professional support.
- Carers' needs for training, support, and clinical services cannot be solely met through a single, time-limited, group training programme. Although training programmes are very important, they are not a panacea.

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Appendices

Appendix A: Summary of the Fostering Changes programme Content (2nd Edition)

A brief outline of the 12 training sessions

NB: These are programme materials taken from the 2nd Edition of the Fostering Changes manual:

Bachman, K., Blackeby, K., Bengo, C., Slack, K., Woolgar, M., Lawson, H., & Scott, S. (2011). *Fostering Changes: How to improve relationships and manage difficult behaviour: A training programme for foster carers*. London, England: British Association for Adoption and Fostering (BAAF).

Session 1: Introduction to the group and to the programme; child resilience; child development; the experiences of foster children; observing and recording child behaviour

Session 2: Causes of child behavioural difficulties; ABC analysis (Antecedents; Behaviour; Consequences); Social Learning Theory; Attachment

Session 3: Understanding child behaviour; using praise

Session 4: Attending to children; the use of play; using praise to help a child's learning

Session 5: Effective communication; helping children to understand and manage their emotions

Session 6: Supporting children's education; carers' managing their thoughts and feelings- using Cognitive Behavioural Therapy

Session 7: Positive reinforcement and consequences; helping children to manage their difficulties and emotions; managing conflict; "I" messages

Session 8: How to give effective instructions; the use of selective ignoring

Session 9: Positive discipline; appropriate consequences; using family rules

Session 10: Using time-out; problem-solving strategies; Stop-Plan-Go strategy; managing emotions during problem-solving

Session 11: Review; helping children make sense of their life story; facilitating positive placement endings; moving into secondary school

Session 12: recognising stress; self-care; ending

Appendix B: The Fostering Changes training programme: Adaptations made by the Canterbury community organisation.

The facilitators of Fostering Changes informed the researcher of the slight adaptations they made to the training programme. Firstly, the facilitators discussed that they placed less emphasis on the education system and educational attainment, which they believed seemed to be more of a focus in the UK. Further, they decided to include more theoretical material on brain development than the manual provided, and so they had an educator from Brain Wave Trust New Zealand give a presentation to the group. The facilitators also discussed that they put greater emphasis on Cognitive Behavioural Therapy (CBT) than the manual. They explained that the aspects of CBT that were integrated were based on a particular facilitator's knowledge gained through her own professional experience.

Appendix C: Information Sheet for caregivers

Note: The name of the Canterbury organisation which ran the Fostering Changes training programme and facilitated this study has been blacked-out with [REDACTED] in this thesis to protect the anonymity of the participants. Any other identifying information is also blacked-out

A study on the Fostering Changes training programme Information sheet for caregivers



Dear [name of caregiver]

I am writing to invite your participation in my study on the Fostering Changes training programme. My name is Loren Whitehead and I am doing a Masters in Child and Family Psychology at the University of Canterbury. I am doing this alongside a Post Graduate Diploma in Child and Family Psychology which is a professional training programme leading to registration as a psychologist. This research project is being carried out as a requirement for my Masters under the supervision of Dr Michael Tarren-Sweeney. At the end of last year Michael was approached by the [REDACTED] who was interested in conducting some research on the Fostering Changes training programme that they run. This study aims to explore how foster carers perceive and experience the effects of participating in the Fostering Changes programme in a 13-15 month period following training.

Why is the research being done?

The studies conducted on the Fostering Changes training programme thus far have not included a follow-up evaluation. It is therefore not known whether the impacts of this training programme are maintained over time. This lack of knowledge not only applies specifically to Fostering Changes but to foster carer training programmes in general. Using follow-up evaluations is important for discovering whether a training programme is able to establish long-term stability of placements, as well as sustained and continued improvement in the behavioural and emotional difficulties of the foster children. This study will help to investigate the type and level of support that caregivers need. It will be an important contribution to research in this area which in turn can help inform policy development regarding intervention for foster carers.

Why are you eligible to participate?

We are looking to recruit foster and kinship carers who have already taken part in the Fostering Changes programme. You have been contacted by the [REDACTED] because you participated in their Fostering Changes training group last year (completion date: [REDACTED]). Your current caregiver status does not affect your eligibility for this study. If you are no longer caring for the child that was with you during your participation in the training programme, this will also not affect your eligibility. If you took part in the training programme as a couple you are required to nominate one caregiver to participate in this study.

What is the involvement of the [REDACTED] in this study?

The [REDACTED] is facilitating this study by providing access to their clients. They are not commissioning the study, nor is the study being carried out on their behalf. They have provided me with information regarding your fostering status at the time of the training programme,

so that I could determine your eligibility in the study. I will not need access to any other personal records/information held by the [REDACTED]. My role is an independent researcher. The [REDACTED] will not be involved in the interviews and will not have access to any of the interview transcripts. They may view the completed thesis given that it is publicly accessible through the University of Canterbury Library database.

What will your participation involve?

Your participation will involve an interview with the researcher that will be between 45 and 60 minutes long. The interview will be audio recorded so that it can be later transcribed. The transcript of your individual interview will be sent to you via email or post. It is strongly advised that children are not present at the interview. An interview time will be arranged with the researcher when your children are at school/kindergarten or when alternative caregiving arrangements can be made. The interview will be conducted in a private office space on the Dovedale campus, University of Canterbury, Ilam. If this location is not feasible then the interview can be conducted in your private home. Participants will receive a small gift as compensation for their time taken to participate in the study.

What kinds of topics will be discussed at the interview?

As the researcher I will ask you about your history of providing foster care, including the type and number of foster care placements you have previously provided, and about your current placement. I will also ask you to reflect on your participation in the Fostering Changes training programme and on the impact that you believe this programme has had on your fostering experience. You will be asked to discuss your fostering experiences during the 13-15 month period since participating in the programme. This may include discussion of your thoughts, feelings, and any events or issues that have occurred which you believe are of significance. You may also be asked to discuss aspects of the programme that you found helpful and those which you think should be changed or improved.

Can you refuse to answer some of the interview questions, or withdraw from the study at any time?

Participation in this study is voluntary. During the interview you may choose not to answer specific questions or withdraw at any time without providing reason. You may withdraw from the study up to two weeks following the interview and any information you provided will be removed. Any raw data you provide can always be deleted from storage but the use of this data in data analysis will be difficult to remove after this two weeks.

How will the information from the interview be used?

The information provided in the interviews will be transcribed and then analysed to identify patterns in the experiences and perceptions of those carers who participated in the Fostering Changes programme approximately 13-15 months ago. It will be written up as a Master's thesis which will be accessible through the University of Canterbury Library database. Participants can be sent a copy of the completed thesis via email. Further publication in a book chapter or journal article is possible.

How will the researcher ensure anonymity and confidentiality?

All of the data that you provide will be kept in locked and secure facilities and/or in a password protected electronic form. This data will then be destroyed 5 years after completing the thesis. Only the researcher (myself) and the [REDACTED] will have access to your real identities. No identifying details of yourself or your family will be included in the transcripts or in the written thesis. Pseudonyms will be used instead of real names.

Who do I contact if I have more questions regarding the study?

Please contact myself or my supervisor if you have any more questions about this study.

What services can I contact if I need any support?

In sharing your fostering experiences during the interview you might experience some emotional distress or feel that you need some further support in your fostering role. I am a trainee child and family psychologist and therefore have acquired some skills that enable me help you deal with any distress if it should arise. I can also provide a referral on your request to the [REDACTED] who will offer their support services. If you would like to seek support elsewhere you are welcome to contact my supervisor detailed below to discuss alternatives.

Thank you for considering participation in this study. If you agree to participate, please complete the consent form attached and return to the address specified.

Kind regards,

Loren Whitehead

Researcher: Loren Whitehead (Masters of Child and Family Psychology student)
Phone: 021 024 00001
Email: lmw144@uclive.ac.nz

Supervisor: Dr Michael Tarren-Sweeney (Associate Professor of Child & Family Psychology & Deputy Head, School of Health Sciences, University of Canterbury, NZ)
Phone: +64 3 364 2987 ext. 7196
Email: michael.tarren-sweeney@canterbury.ac.nz

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee. Participants should address any complaints to:

The Chair, Human Ethics Committee
University of Canterbury
Private Bag 4800, Christchurch

Email: human-ethics@canterbury.ac.nz

Appendix D: Consent form for caregivers

Note: The name of the Canterbury organisation which ran the Fostering Changes training programme and facilitated this study has been blacked-out with [REDACTED] in this thesis to protect the anonymity of the participants.

A study on the Fostering Changes training programme Consent form for caregivers



- I have read the information sheet and have been given the opportunity to ask questions about the study. I understand what is required of me if I agree to take part in the study.
- I understand that the study will be written up as a Master's thesis, which will be publicly accessible via the University of Canterbury Library database, and that further publication in a book chapter or journal article is possible.
- I understand that the participation is voluntary and that I may withdraw from the study up to two weeks following the interview. Withdrawal of participation will also include the withdrawal of any information I have provided.
- I understand that any information I provide will be confidential and that the written thesis will not reveal my real identity. Only the researcher and the [REDACTED] will have access to my real identity.
- I understand that the [REDACTED] will not be involved in the interview and will not have access to any of the interview transcripts.
- I understand that all data collected for the study will be kept in locked and secure facilities and/or in a password protected electronic form and will be destroyed five years after the completion of the thesis.
- I understand that in sharing my fostering experiences during the interview I might experience some emotional distress or feel that I need some further support in my fostering role. If this is the case, I understand that the researcher will do their best to support me and will refer me to the appropriate services if I wish.
- I understand that I will be emailed or posted the transcript of the interview, and that I have access to the completed thesis.
- I understand that I can contact the researcher or supervisors for further information.

By signing below, I agree to participate in this research project.

***Name:**

***Signature:**

***Date:**

***Email address:**

Please tick the box if you would like to be emailed/posted a copy of the completed thesis

** All denoted fields must be completed.*

- Please return this form using the Reply-Paid envelope
- You will be contacted by the researcher after they have received this form, to organise a time and location for the interview.

Appendix E: Interview schedule (first interview)

Topic 1: *“Tell me about your history of providing foster care”*

Probes:

- Number of years fostering
- Type of foster care (e.g. long-term, short-term)
- Number of foster children in total
- Agencies/authorities associated with
- Biological children
- Current fostering status: type; number of foster children; same child as when on the training course?
- Attendance at other training courses?
- Why did you attend Fostering Changes?

Topic 2: *“Tell me about your experiences participating in the Fostering Changes programme”*

Topic 2 later removed

Probes:

- Group dynamic
- Content: theory, skills, practice
- Facilitators
- Time: length, frequency
- Location
- *Was it what you had hoped?*
- *Was it what you expected? Did it meet your expectations?*
- What didn't it cover?

Topic 3: *“Tell me about your fostering experience during the 12 weeks while you were on the course”.*

Topic 3 later removed

Topic 4: *“Tell me about your fostering experience after completing the Fostering Changes programme”*

- Initially, over time, currently

Example questions:

- *“How would you relate this change to the training programme?”*
- *“How did this evolve over time?”*
- *“What aspects of the training programme had the biggest impact on your caregiving experiences?”*
- *“What changes, if any, have you noticed in you fostering experience since completing the programme?”*
- *“What changes, if any, did you notice in your fostering experience during the first few months following the training programme? Did this change over time, and if so how?”*
- *“In what ways, if any, do you think the Fostering Changes training programme has influenced your fostering experience currently?”*

Probes: the same for Topic 3 and 4 (initially, over time, currently):

Caregiver

- Caregiving/parenting (behaviour management, understanding their child's difficulties, responding to their child's behaviour)
- Remembering the skills – putting them into practice after the programme
- Confidence/efficacy (to manage and understand child, to make a difference)
- Wellbeing of carer e.g. stress
- Feelings about yourself as a caregiver: you are/are not doing a good job, you are/are not confident that the placement will continue, you are happy/unhappy in your role, you want /do not want to continue with this role, you get/do not get satisfaction out of this role
- Feelings/attitudes about fostering: similar to above, want to continue fostering? Or feel like giving up?

Child

- Child behaviour (emotional, behavioural, social, attachment, pro-social/strengths, peer problems)

Child-carer relationship

- Does the child seek you out for comfort? Push you away?
- Child trust you?
- Child accept your affection?
- Communication between you and the child; understanding each other

Family

- Wellbeing of family
- family functioning
- sibling relationship
- other foster children or biological children

Placement disruption/breakdown?

- Why? When?
- How was that for you and your family?
- Why do you think the placement has continued successfully?
- Plans for a new placement?
- Was there anything in the programme that helped or didn't help with this breakdown
- Is there anything you wish they covered in the programme that would of helped you through this process better?

Topic 5: *“I would really like to hear about your perspectives regarding training for foster carers and how it should be run – how you think it should be”*

Probes

- What changes, if any, would you make to Fostering Changes and why?
- What is important to include in training?
- Should it be compulsory?
- Frequency of training?
- Do you think you’ve had enough?
- How do you feel now? More training?

Appendix F: Interview schedule (revised version)

Topic 1: *“Tell me about your history of providing foster care”*

Probes:

- Number of years fostering
- Type of foster care (e.g. long-term, short-term)
- Number of foster children in total
- Agencies/authorities associated with
- Biological children
- Current fostering status: type; number of foster children; same child as when on the training course?
- Attendance at other training courses?
- Why did you attend Fostering Changes?

Topic 2: *“Tell me about your fostering experiences after completing the Fostering Changes programme”*

Key notes to self and example questions

- Go with what they talk about first; they might start with the current effects first or they might start talking about the effects initially after the programme.
- “What have things been like in terms of your X (e.g. stress levels), over the last year since completing the programme?”
- “Tell me about your X (e.g. stress) over the last year since completing the programme?”
- If they have described a particular effect, and in enough detail, then ask (examples below):
 - “What was this like initially after completing the programme (in the first initial months)?”
 - “What was this like over the last year since completing the programme?”
 - “What was this like before you started the programme?”
 - “What is this like now?”
 - “How has that been over the last year up until now?”
 - “How did that evolve over time?” “Did it get worse, stay the same, or get better?”
 - “How has this change/impact varied over time?”
 - “How would you relate this/these changes to the training programme?”
- If you need to seek more detail then ask the following (examples below):
 - “How have you seen this?”
 - “Can you give me an example of how you have used this/seen this play out?”
 - “What has this been like for you?”

Probes (for initially, over time, and currently):

Caregiver

- Caregiving/parenting (behaviour management, understanding their child's difficulties, responding to their child's behaviour)
- Remembering the skills – putting them into practice after the programme
- Confidence/efficacy (to manage and understand child, to make a difference)
- Wellbeing of carer e.g. stress
- Feelings about yourself as a caregiver: you are/are not doing a good job, you are/are not confident that the placement will continue, you are happy/unhappy in your role, you want /do not want to continue with this role, you get/do not get satisfaction out of this role
- Feelings/attitudes about fostering: similar to above, want to continue fostering? Or feel like giving up?

Child

- Child behaviour (emotional, behavioural, social, attachment, pro-social/strengths, peer problems)

Child-carer relationship

- Does the child seek you out for comfort? Push you away?
- Child trust you?
- Child accept your affection?
- Communication between you and the child; understanding each other

Family

- Wellbeing of family
- family functioning
- sibling relationship
- other foster children or biological children

Placement disruption/breakdown?

- Why? When?
- How was that for you and your family?
- Why do you think the placement has continued successfully?
- Plans for a new placement?
- Was there anything in the programme that helped or didn't help with this breakdown
- Is there anything you wish they covered in the programme that would of helped you through this process better?

- *“What aspects of the programme had the biggest impact on your fostering experience?”*
- *“What challenges do you continue to face/experience?”*
- *“What would things be like for you and your family if you hadn't of attended the Fostering Changes programme?”*

Questions added to the original version

Topic 3: *“I would really like to hear about your perspectives regarding training for foster carers and how it should be run – how you think it should be”*

Probes

- What changes, if any, would you make to Fostering Changes and why?
- What is important to include in training?
- Should it be compulsory?
- Frequency of training?
- Do you think you’ve had enough?
- How do you feel now? More training?

Appendix G: Ethics approval



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2015/50

2 July 2015

Loren Whitehead
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Loren

The Human Ethics Committee advises that your research proposal “Long-term evaluation of the fostering changes training programme.” has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 21 June 2015.

Best wishes for your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'L MacDonald'.

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee